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# ROYAL COMMISSION ON HEALTH SERVICES

**HEARINGS**

HELD AT

**TORONTO**

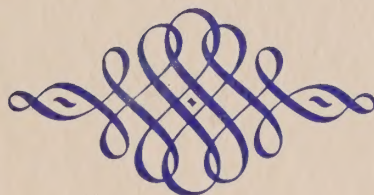
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VOLUME 54

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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 16th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R. N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O.J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE







---On resuming at 9:30 a.m.

THE SECRETARY: The first brief this morning is the Canadian Health Insurance Association which will be exhibit number 280, and Mr. Reid will introduce his confreres at the table.

---EXHIBIT NO. 280: Submission of the Canadian Health Insurance Association.

SUBMISSION OF  
CANADIAN HEALTH INSURANCE ASSOCIATION

APPEARANCES: Mr. R. Reid  
Mr. G. W. Fitzhugh,  
Dr. J. C. Emmett,  
Mr. H. A. Austin  
Mr. R. N. Mackintosh,  
Mr. J. E. Morrison  
Mr. G. N. Watson  
Mr. C. L. Drewry  
Mr. J. Robinette, Q.C.

MR. REID: I am R. H. Reid, President of The London Life Insurance Company, and I am appearing this morning as President of the Canadian Health Insurance Association.

With me are: Mr. Gilbert W. Fitzhugh, Executive Vice-President, Metropolitan Life Insurance Company; Dr. James C. Emmett, Medical Director, The Imperial Life Assurance Company of Canada, who are co-chairmen of CHIA's Special Committee on Medical Care Plans, and Mr. H. A. Austin, Vice-President in charge of Canadian Operations, The Prudential Insurance Company of America; Mr. R. N. Mackintosh, Manager, Group Division,







Reid

10237

Zurich Insurance Company; Mr. J. E. Morrison, Executive Vice-President, The Great-West Life Assurance Company; Mr. G. N. Watson, Group Vice-President, The Crown Life Insurance Company and Mr. Corbet L. Drewry, in the Managing Director, Canadian Health Insurance Association.

This is the second occasion on which our Association has been privileged to appear before you.

The first occasion was in Halifax last Fall.

Since then, two of our member companies -- the Great-West Life Assurance Company and the Metropolitan Life Insurance Company represented at that time by Mr. Fitzhugh and Mr. David Kilgour -- with the full agreement of our Association have appeared before you in Ottawa.

We are thus making our Submission to you this morning with the knowledge that you have already received a good deal of what we hope has been to you useful information about our business.

My other colleagues and I have had an opportunity to study the transcripts of the Hearing in Ottawa, and we have informed Mr. Fitzhugh -- and would like to confirm to you -- that as an Association we fully endorse the testimony he and Mr. Kilgour presented to you on that occasion.

At the Halifax Hearing last Fall Dr. Firestone asked certain specific questions of us and indicated that these could be answered when the Submission of the Association was presented to you.



The Insurance Company and Mr. Connel L. Brown,

Managing Director, Canadian Health Insurance Association.

This is the second occasion on which

our Association has been privileged to appear before

The first occasion was in Halifax

last Fall.

Since then, two of our member companies

-- the Great-West Life Insurance Company and the

Metropolitan Life Insurance Company represented at that

time by Mr. Widdup and Mr. David Kilgus -- with the

representatives of our Association have appeared before you

in Ottawa.

We are thus making our submission to

you this morning with the knowledge that you have already

received a good deal of what we hope has been to you

valuable information about our business.

My other colleagues and I have had an

opportunity to study the transcript of the hearing

in Ottawa, and we have informed Mr. Widdup -- and

also I like to mention to you -- that as an Association

we fully endorse the testimony of Mr. and Mrs. Kilgus.

I would like to say on that occasion.

At the Halifax hearing last Fall

the question of certain areas is question of the

testimony that these areas are the same as the

testimony of the Association as presented to you.



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4 Several of these questions were  
5 extensively explored in the discussions which Mr. Kilgour  
6 and Mr. Fitzhugh had with you in Ottawa, and we believe  
7 that either in the testimony which they gave or in the  
8 Submission which our association is now presenting to  
9 you all of the points upon which Dr. Firestone has  
sought information by his questions are covered.

10 It may be that you will wish to  
11 consider these replies with us in further detail and  
12 we shall of course be more than happy to do this.

13 However, since this area was canvassed  
14 very extensively in Ottawa, and since we recognize that  
15 with over 140 Submissions to be heard in Toronto time  
16 is to some degree of the essence, our thought, Mr.  
17 Chairman, is that you might perhaps prefer us to deal  
18 in the first instance with the illustrative plan for  
19 the extension of medical care insurance which is out-  
20 lined in our Submission. This is a plan which we firmly  
21 believe to be a constructive and practical approach to  
22 at least one of the problems with which you are con-  
23 fronted.

24 Unless you wish me to do so, I do not  
25 propose to read the summary and recommendations which  
26 are found on pages 1 to 6 of our Submission, because  
27 in some measure they merely repeat and re-enforce the  
28 statements made in Halifax.

29 You will remember that there we said  
30 we were developing a plan to make medical care insurance  
available to all Canadians able to pay a reasonable  
premium, regardless of health, age, occupation or place





Several of these questions were

extensively explored in the discussion which Mr. Wilson and Mr. Pittman had with you in Ottawa, and we believe that rather in the testimony which they gave in the discussion which our association is now presenting to you all of the points upon which Dr. Fingleton has sought information by his questions are covered.

It may be that you will wish to

consider these replies with us in further detail and we shall of course be more than happy to do this.

However, since this area was canvassed

very extensively in Ottawa, and since we recognize that

with over 140 Submissions to be heard in Toronto time

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Chairman, is that you might perhaps prefer us to deal

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fronted.

Unless you wish me to do so, I do not

propose to read the summary and recommendations which

are found on pages 1 to 6 of our Submission, because

in some measure they merely repeat and re-state the

statements made in earlier

You will remember that these we said

we were adopting a plan to make medical care insurance

available to all through the idea to pay a reasonable

and fair, reasonable of health, and, occupation or place



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3 of residence. The proposals outlined in Appendix II,  
4 which Mr. Drewry will later read, if you care to have  
5 him do so, describe one practical method for achieving  
6 this objective.

7 The plan put forward is a type which  
8 our industry believes can be successfully developed  
9 with our member companies, the vast majority of whom  
10 have already pledged themselves to the achievement of  
11 this objective. Before asking Mr. Drewry to read a  
12 very brief summary of the advantages we feel the plan  
13 has, I should like to emphasize, sir, that we are here  
14 with the earnest desire to be of assistance in any way  
15 that we can in the very formidable task facing your  
16 Commission.

17 I might, Mr. Chairman and Commissioners,  
18 say that I am merely a front-man here, and we have got  
19 in particular Mr. Fitzhugh, who is the principal  
20 architect of this plan, and any questions you may wish  
21 to ask us I would like him to be the spokesman for our  
22 Association, although he may wish to call on certain  
23 other members of our delegation, and we have some  
24 technical experts in the background, in case you throw  
25 us any knuckle-balls that we might not be able to handle  
26 ourselves, so we have got a few people in the background,  
27 although I have found that Mr. Fitzhugh in general is  
28 able to handle himself very well without much help.

29 Mr. Chairman, is it agreeable to you  
30 if Mr. Drewry proceeds on the basis I have suggested,  
to outline the plan briefly and point out what we think  
are some of the advantages of it?



to residential. The residential office is located in  
which the member will later need, if you care to have  
this to do, according to the practical method for solving  
this problem.

The plan for tomorrow is a two-part:

our industry believes can be successfully developed  
with our member companies, the vast majority of whom  
have already pledged themselves to the wholehearted  
this objective. Before asking Mr. Brown to read a  
very brief summary of the advantages we feel the plan  
has, I should like to emphasize, sir, that as the here  
with the annual meeting to be of assistance in any way  
that we can in the very formal task facing you.

I think, Mr. Chairman and Commissioners

and that I am certain a long-term plan, and we have not  
in particular Mr. Littleton, who is the principal  
element of this plan, and any questions you may wish  
to ask us I would like him to be the spokesman for our  
position, although he may wish to call on certain

other members of our delegation, and we have some  
technical experts in the background, in case you throw  
us any knotty-knotted questions that we might not be able to handle  
ourselves, so we have not a few people in the background.  
Although I have found that Mr. Littleton is general in  
scope to handle himself very well without your help.

Mr. Chairman, it is a pleasure to you

I am very pleased on this date I have presented  
to outline the plan briefly and point out what we think  
are some of the advantages of it.





Reid

10240

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4 THE CHAIRMAN: We are quite prepared  
5 to follow whatever way you wish to handle it. If I  
6 might make this suggestion, the plan is a practical  
7 thing, you have put it forward as a practical thing.  
8 Would you care to preface it with the philosophical  
9 approach as to why you went about to construct a plan  
10 in the first place, and what ought to be the approach  
11 to the providing of health services, making health  
12 services available to Canadians, and Dr. Firestone adds  
13 the question of prepayment, but I wouldn't restrict you.

14 MR. REID: Well, if I may merely  
15 express a personal view, Mr. Chairman, from my own  
16 standpoint, and I think this is true of many of our  
17 companies, although we have quite a variety of different  
18 types of companies, but personally my greatest concern  
19 has been to avoid the government plan, which I think  
20 might, on a compulsory basis covering everybody, which  
21 I think would inevitably be very expensive indeed,  
22 whereas we feel that on a voluntary basis the field of  
23 government assistance can be limited in very, very  
24 substantial measure, although we do recognize that there  
25 may well be a place besides what governments are doing  
26 now for some type of assistance, but in general our  
27 thought has been, or the thinking of many of us has  
28 been influenced far more by our desire not to have the  
29 economy overloaded by a very heavy burden of additional  
30 government expenditure, and I think even more important  
that the quality and availability of medical care should  
not deteriorate if the doctors in effect are gradually  
conscripted.





Reid

10241

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4 That, I think, is one of the reasons  
5 that we have formulated this plan. Mr. Fitzhugh might  
6 have a slightly different philosophy and wish to express  
7 some thoughts on the subject too.

8 MR. FITZHUGH: I think you have  
9 covered it very well. You have asked us for a statement  
10 on philosophy, so I hope you will bear with us if we  
11 give you a little philosophy.

12 THE CHAIRMAN: We are quite happy to  
13 have you do it, and it is not a question of just putting  
14 up with it. We are inviting you.

15 MR. FITZHUGH: I will be brief, because  
16 as Mr. Reid says, time is of the essence.

17 THE CHAIRMAN: Well, I wouldn't want  
18 you to think we are short of time to discuss the basic  
19 philosophies of the issues that are before us.

20 MR. FITZHUGH: I appreciate that, too  
21 sir. As Mr. Reid said, we naturally approach this from  
22 the point of view of the voluntary enterprise system.  
23 That is no surprise to you. Putting aside our selfish  
24 interest ---

25 THE CHAIRMAN: Yes, putting aside the  
26 personal interest, that is natural ---

27 MR. FITZHUGH: We have honestly tried  
28 to be objective, as well as anybody can be objective,  
29 when we obviously have a starting point in view, and from  
30 our at least projected point of view we feel it is  
essential for the successful development of medical care  
in Canada that individual Canadians have a choice of  
plan. That any uniform plan, no matter how good it is





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that we have formulated this plan. Mr. Fitzhugh might  
have a relatively different philosophy and wish to express  
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That is no surprise to you. Putting aside our selfish

THE CHAIRMAN: Yes, putting aside the  
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MR. FITZHUGH: We have honestly tried  
to be cooperative, as well as anybody can be objectively,  
when we obviously have a differing point of view, and for  
you at least proposed point of view we see it is  
essential to the successful development of medical care  
in that that individual members have a right to  
state. There are uniform plans, no matter how good it is



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4 at the outset, must of necessity, by definition, be a  
5 uniform plan applicable to everyone and maybe the same  
6 plan is not the best for 18 million Canadians. Some may  
7 want one plan, some may want another. They have proved  
8 that by their actual selection in the marketplace of  
9 different types of plans. Some have chosen indemnity  
10 type plans, some have chosen some other types, you know  
11 the various types of plans. So they would not all want  
12 one plan, which is what they would have to have under a  
13 government plan.

14 Secondly, we feel voluntary plans have  
15 more flexibility. Assume that we were able to develop  
16 the ideal government plan. How long would that remain  
17 the ideal plan? We feel that one government plan would  
18 be much more difficult to change to meet changing  
19 circumstances and voluntary plans have been shown to be  
20 able to do this.

21 Third, we feel that inherent in the  
22 voluntary system is the economies resulting from  
23 competition. Any monopoly system has built-in higher  
24 cost it seems to us, and not only cost, but service. We  
25 believe the competitive system produces lower cost,  
26 better quality care, and more extensive coverage, and  
27 each of hundreds of different carriers of our prepayment  
28 plans, trying to outdo each other in doing a better  
29 job for the public, introduce advances, not only in  
30 medicine, but all phases of our life.

Fourthly, we believe firmly in individual  
decisions in a matter of this importance rather than  
a few basic decisions being made for everybody by a



at the outset, must of necessity, by definition, be a uniform plan applicable to everyone and hence the same plan is not the best for all. In fact, there are many different types of plans. Some have chosen industrial type plans, some have chosen some other types, you know the various types of plans. So they would not all want one plan, which is what they would have to have under a

country, we feel voluntary plans have some flexibility. Assume that we were able to develop that that government plan. How long would that remain a fixed plan? We feel that one government plan would be much more difficult to change to meet changing circumstances and voluntary plans have been shown to be able to do this.

What, we feel that inherent in the voluntary system is the economic results for competition. Any monopoly system has built-in inefficiency. It costs it more to do, and not only cost, but also, we believe the competitive system does have lower cost, better quality cost, and more extensive coverage, and a lot of hundreds of different examples of our country and abroad, moving to outside each other in doing a better job for the public, introduce advances, not only in medicine, but all phases of our life.

Incidentally, we believe that in a free society, in a matter of this kind, we rather than a few basic decisions being made for everyone by a





Fitzhugh

10243

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4 relatively few people who, no matter how well informed,  
5 and even if it is the best decision, some people are making  
6 a decision affecting 18 million people, and we feel you  
7 get a better decision in the long-run by people making  
8 their own choices.

9 Fifth, we feel the present voluntary  
10 system is providing medical care for a great many  
11 Canadians, and under the proposed plan can for a great  
12 many more at little or no cost to the taxpayer or the  
13 government. Any monopoly government plan we have heard  
14 proposed involved great expense to the taxpayer. We  
15 admit that the visible expenses of a voluntary system  
16 are higher than a uniform government system. There is  
17 no point in debating that, but those are the visible  
18 costs. There are many invisible costs of a monopoly  
19 government. The hidden cost of collecting the taxes,  
20 and we feel the claim cost under the government system  
21 is bound to rise, so the total cost of the program would  
22 be higher under a government plan.

23 Finally, number six, the most important  
24 one, as Mr. Reid said, is that we firmly believe that  
25 the voluntary system preserves and strengthens the  
26 quality of medical care for Canadians, and we are much  
27 afraid that a monopolistic government plan would  
28 inevitably lead to deterioration in the future. We  
29 cannot prove that, but we know what we have got, and  
30 we know it is good, and we think it is too important to  
risk what might happen if we change the ground rules.  
We are not so much concerned with what might happen  
right now, we are concerned of course, but we are



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relatively few people who, no matter how well informed, and even if it is the best decision, some people are making a decision affecting 13 million people, and we feel you get a better decision in the long-run by people making their own choices.

Fifth, we feel the present voluntary

system is providing medical care for a great many Canadians, and under the proposed plan can for a great many more at little or no cost to the taxpayer or the government. Any monopoly government plan we have heard proposed involved great expense to the taxpayer. We admit that the visible expenses of a voluntary system are higher than a uniform government system. There is no point in debating that, but those are the visible costs. There are many invisible costs of a monopoly government. The hidden cost of collecting the taxes, and we feel the claim cost under the government system is bound to rise, so the total cost of the program would be higher under a government plan.

Sixth, number six, the most important

one, as Mr. Reid said, is that we firmly believe that the voluntary system preserves and strengthens the quality of medical care for Canadians, and we are much afraid that a monopolistic government plan would inevitably lead to deterioration in the future. We cannot prove that, but we know what we have got, and we know it is good, and we think it is too important to risk what might happen if we change the ground rules. It is not so much concerned with what might happen right now, we are concerned of course, but we are



Fitzhugh

10244

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4 concerned with the quality of medical care for our  
5 children and our grandchildren; that the doctors  
6 presently in being grow up with the idea of being  
7 individual practitioners. They have a mission in life,  
8 or they wouldn't be doctors. Will you get the same  
9 kind of doctor coming into the medical schools and  
10 coming into the profession in the future if we have a  
monopolistic plan? We don't want to take that chance.

11 We think that has been evident in  
12 England. Whether the plan over there is a success or  
13 not is an arguable point. You will get opinions on  
14 both sides, but we are not too sure whether it is too  
15 important. What we are concerned with is will it be  
16 successful in the future, and the trouble England is  
17 having in keeping its hospitals staffed with English  
18 doctors and having them emigrate worries us as to the  
19 quality of medical care that would come in the future  
20 under a government plan.  
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STOMACH  
TONGUE

concerned with the quality of medical care for our  
children and our grandchildren, that the doctors  
presently in being grow up with the idea of being  
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not is an arguable point. You will get opinions on  
both sides, but we are not too sure whether it is too  
important. What we are concerned with is will it be  
successful in the future, and the trouble England is  
having in keeping its hospitals staffed with English  
doctors and having them emphasize worries as to the  
quality of medical care that would come in the future  
under a government plan.



Fitzhugh

10245

1/dpw

The reason we think that is so serious is because a monopoly government plan, the government, any responsible government, could just not throw carte blanche to the doctors and say "You run it the way you like and we will pay the bill." They cannot do that but neither can private business. They would have to have some control over costs and that inevitably means budgetary controls over the quality of medical care because of the necessary budgetary controls, as Mr. Reid says, in effect, it is conscription of an entire profession.

We do not see why the doctors, any more than lawyers or actuaries or bricklayers, should be told "If you want to be a bricklayer you do it under the terms we set down or you cannot be a bricklayer in Canada." So, with that philosophic background of the advantages of voluntary versus monopoly segments we look to the voluntary plans and state what is wrong with them and how can we improve them to cover more people?

As you have been told, there are some 10% of Canadians who have a plan. As we said in Halifax we recognize there are several methods; we need more rapid expansion to see how we can improve the voluntary plans, make them available to every man, woman and child in Canada regardless of age, sex, physical condition. We feel if we can fill in those gaps we would overcome the one thing, the present disadvantage of the voluntary plan and make it unnecessary to go into a monopoly government plan which seems to us to have serious disadvantages.



Pittsburgh

The reason we think that is so serious

my best belief government, could just not throw out  
finance to the doctors and say "You run it the way you  
like and we will pay the bill." They cannot do that  
and neither can private business. They would have to  
have some control over costs and that inevitably means

because of the necessary budgetary controls, as Mr. Reid  
says, in effect, it is a recognition of an entire profes-  
sion.

We do not see why the doctors, any more  
than lawyers or accountants or bricklayers, should be told  
"If you want to be a bricklayer you do it under the  
terms we set down or you cannot be a bricklayer in Canada."  
With that philosophic background of the advantages  
of voluntary versus monopoly segments we look to the  
voluntary plan and state what's wrong with them and  
how can we improve them to cover rate payers.

As you have been told, there are a few  
people in the profession who have a plan. As we said in Halifax  
in 1962, there are several models; we need more  
basic information to see how we can improve the voluntary  
plan, what is available to every man, woman and child.  
In terms of fairness of age, sex, physical condition,  
to feel if we can fill in those gaps we would overcome  
the one thing, the present disadvantage of the voluntary  
plan and if necessary, to go into a monopoly  
which would seem to us to have serious disadvantages.





Fitzhugh

10246

THE CHAIRMAN: Thank you very much.

MR. REID: You see we have a very eloquent spokesman.

MR. FITZHUGH: That is a self-serving statement.

MR. REID: Would it be appropriate for Mr. Drewry to give a brief outline of the specific plan and comment a little further on what we think are the advantages of them? I think Mr. Fitzhugh has covered it in a large measure.

THE CHAIRMAN: Now we will come to the practical.

MR. REID: We would like to outline the specific plan we are proposing because we think that is perhaps the main purpose of our appearance here today, to outline what we think is a feasible plan to cover a very high proportion of the total population recognizing that there will still be certain gaps, inevitably.

We do think that this can fill a large portion of the gaps. I would like Mr. Drewry to outline it.

THE CHAIRMAN: Thank you.

MR. DREWRY: I would very much prefer to sit down while I am reading from Appendix II and this section is headed "Description of an Illustrative Plan Proposed by Canadian Health Insurance Association for the Extension of Medical Care Insurance."

1. ELIGIBILITY —

The plan will be available to everyone in Canada regardless of age, condition of health,



THE CHAIRMAN: Thank you very much.

MR. BRYAN: You see we have a very

MR. FITZGERALD: That is a self-servicing

Mr. Brewster to give a brief outline of the specific plan and comment a little further on what we think are the advantages of them. I think Mr. Fitzgibbon has covered it in a fairly measure.

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MR. BRYAN: I would very much prefer to sit down while I am reading from appendix II and this section is named "Description of an illustrative plan proposed by Canadian Health Insurance Association for the Extension of Medical Care Insurance."

The plan will be available to everyone

in Canada the release of age, location of health,



Drewry

10247

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2  
3 occupation or geographic location. People who have been  
4 unable to secure medical care insurance from existing  
5 facilities will, if this plan is adopted, be able to  
6 secure such insurance. The broad coverage will be made  
7 possible by the plan's method of pooling the extra  
8 medical care costs incurred by these people, as will be  
9 described later herein.

10 The plan proposes that all insurers  
11 selling individual or family policies of medical care  
12 insurance will make available two standardized plans of  
13 medical care insurance in the form of both individual  
14 and family policies. Under the proposed plan, these  
15 policies will be available to everyone, regardless of  
16 age, state of health, occupation, or geographic location  
17 in Canada, for a period after the introduction of the  
18 plan during which application for coverage must be made.  
19 This period may be, for example, three months. Subse-  
20 quently, application during a shorter period (probably  
21 forty-five days) may be made each year thereafter by  
22 residents not already covered for benefits.

23 In a few special situations residents will  
24 also be able to obtain these policies at other times, and  
25 on the same terms. For example, it is proposed that a  
26 period of thirty days be allowed following termination  
27 of coverage under a group policy providing medical care  
28 benefits during which a person would be able to obtain  
29 one of these policies, regardless of his state of health,  
30 age, occupation or geographic location.







Drewry

10248

2. SOURCES OF COVERAGE -

This proposed plan has been approved in principle by all of our members who have studied it. These companies account for over 85% of the total premium income of our membership.

When the plan is adopted any person in Canada can apply to any insurance company in the individual and family field for a Standard Policy providing medical care benefits for himself and members of his immediate family. Each person will have complete freedom of choice as to the company to which he wishes to apply. In order to give each person the advantage of the lowest possible rate, companies will probably ask for a health history, but regardless of factors that might increase the premium, the plan proposes that the Standard Policy must be made available at a premium rate not to exceed an amount that will be established by statutory formula.

THE CHAIRMAN: I wonder if you could expand on that? Just how practical that idea is in terms of ten provinces having jurisdiction over insurance.

MR. DREWRY: I think I would like Mr. Fitzhugh to answer that question. The principle is that by appropriate provincial legislation which has the jurisdiction over the insurance field, there would be established a maximum premium beyond which the companies could not charge and below that maximum there would be complete freedom and complete competition among all the different carriers.

THE CHAIRMAN: Did you envisage that it would have to be at the ten provinces - the ten

1. A HISTORY OF CANADA -

This proposed plan has been approved in principle by all of our members who have studied it. These companies account for over 85% of the total premium income of our membership.

When the plan is adopted and passed in Canada can apply to any insurance company in the individual and family field for a standard policy providing medical care benefits for himself and members of his immediate family. Each person will have complete freedom of choice as to the company to which he wishes to apply. In order to give each person the advantage of the lowest possible rate, companies will probably ask for a health history, but regardless of factors that might increase the premium, the plan proposes that the standard policy must be made available at a premium rate not to exceed an amount that will be established by statutory formula.

THE CHAIRMAN: I wonder if you could

expand on that? Just how practical that idea is in terms of ten provinces having jurisdiction over insurance.

MR. BRETHER: I think I would like Mr. Fitzpatrick to answer that question. The principle is that by appropriate provincial legislation which has the jurisdiction over the insurance field, there would be established a maximum premium beyond which the companies could not charge and below that maximum there would be complete freedom and complete competition among all the different companies.

THE CHAIRMAN: Did you envisage that

it would have to be at the ten provinces - the ten





Drewry

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provinces would have to co-operate and co-ordinate that legislation?

MR. DREWRY: Definitely; and it is conceivable you may have differences between the provinces.

COMMISSIONER McCUTCHEON: Just a maximum premium for a minimum benefit.

MR. DREWRY: For a basic coverage, yes.

THE CHAIRMAN: Thank you.

MR. DREWRY: 3. BENEFITS - After consultation with the medical profession, the Association has developed a suggested schedule of benefits which could be provided under the plan. This schedule should be regarded as illustrative only of the range of cover which might be provided and it could be extended if thought desirable. It must be recognized, however, that additional benefits would require reconsideration of the level of the proposed premiums.

The illustrative plan provides insurance for the expenses of surgical and medical services, rendered to the insured or, in family policies, to the insured and to the insured members of his family:

(a) For surgical and medical services, the benefits are based upon the regular and customary fees for necessary services as related to the tariffs of medical fees promulgated by the provincial Division of The Canadian Medical Association of the province in which the policy was issued. Benefit payments will be

provisions would have to co-operate and co-ordinate that legislation.

MR. DREWRY: In addition, and it is

conceivable you may have differences between the

COMMISSIONER OF INSURANCE: Under a maximum

premium for a minimum benefit.

MR. DREWRY: For a basic coverage, yes.

MR. CHALKMAN: Thank you.

MR. DREWRY: A. F. H. - After consult-

ation with the medical profession, the Association has developed a suggested schedule of benefits which could be provided under the plan. This schedule should be regarded as illustrative only of the range of cover which might be provided and it could be extended in thought desirable. It must be recognized, however, that additional benefits would require reconsideration of the level of the proposed premiums.

The illustrative plan provides insurance

for the expenses of surgical and medical services,

rendered to the insured or, in family policies, to the

insured and to the insured members of his family:

(a) for surgical and medical services,

the benefits are based upon the charges and charges for necessary services as related to the tariff of medical

fees provided by the principal

Division of the Canadian Medical Association

tion of the hospital in which the policy

was issued. Where payments will be



Drewry

10250

made to the insured unless otherwise directed by him.

(b) The Standard Plan includes payment for physicians' charges only in the event of illness or accident and the benefits are subject to an overall lifetime maximum limit per individual of \$5,000.00. (This figure has been put in for illustrative purposes and in order to determine a premium.) I would add that it is not necessarily a fixed figure, we had to have an illustrative figure. Within that limit it provides reimbursement.

(i) In full for the charges according to the applicable provincial tariff for practice in general for registered medical practitioners for a patient admitted to a hospital (as defined for purposes of the Provincial Hospital Insurance Plan) as an in-patient for:

Surgical treatment,

Physicians' attendance,

Anaesthetics,

Obstetrical care and delivery (applicable to family coverage only),

All diagnostic, X-ray, and laboratory services (except those paid by the Provincial Hospital Insurance Plan).

THE CHAIRMAN: The qualification being that of an in-patient?

MR. DREWRY: An in-patient on this first





1957

able to the insured unless otherwise

stated in the policy.

(c) The Standard Plan in force on the

the provisions, changes only in the

event of illness of accident and the

benefits are subject to an overall

limitation which can limit per individual

of \$2,000.00. (This limit has been

put in for illustrative purposes and

in order to determine a premium.) It

would add that it is not necessarily

a fixed figure, we had to have an

it provides a limit.

(d) It falls for the charges according

to the applicable provincial tariff

for practice in general for registered

medical practitioners for a period

admitted to a hospital (or deemed for

purposes of the Provincial Hospital

Insurance Plan) as an inpatient, form

provisional cases and delivery  
applicable to family coverage only.

All diagnostic, X-ray, and laboratory  
services rendered while in the  
Provincial Hospital Insurance Plan.

The Ontario Health Insurance Board

Board of an in-patient

W. L. H. : As a result of this



Drewry

10251

group of benefits; then there are also out-of-hospital benefits which I will refer to later.

Where services are rendered by a certified specialist, there will be additional reimbursement up to 50% of the excess of the fee provided in the tariff for a certified specialist over that for a general practitioner.

Where there is no differential, the full tariff applicable to specialists will be paid.

(ii) For physicians' charges out of hospital or while patient is an out-patient. When patient at a hospital, benefits will be 80% (50% for psychiatric care) of the tariff charges (whether of a specialist or general practitioner) in excess of a deductible of \$10.00 per illness or accident. When the \$10.00 deductibles per illness or accident have amounted to \$50.00 for any family in any calendar year, there will be no further deductibles for that year. Where the illness is due to the same or related causes, a 90-day interval between services will be the criterion for determining whether the claim shall be treated as a new illness.

(c) The plan contains appropriate provisions for non-duplication of benefits



...of benefits, then this also would not be  
...which will refer to later.

Where services are rendered by a  
certified specialist, there will be  
additional reimbursement up to 50% of  
the excess of the fee provided in the  
tariff for a certified specialist over  
that for a general practitioner.  
Where there is no difference, the  
full tariff applies to specialists.

(11) For specialists' charges out of  
hospital or while patient is in out-  
patient at a hospital, benefits will  
be 80% (50% for day hospital cases) of  
the tariff charges (whether of a  
specialist or general practitioner)  
in excess of a fixed fee of £1.10  
per line or consultation. When the  
fixed fee applies per line or  
consultation, the total fee for  
any facility, in any calendar year, there  
will be no further benefits for that  
year. Where the tariff is used to the  
full, no further benefits will be  
allowed. But an amount will be  
allowed for hospital in-patients.  
This shall be treated as a separate  
(12) The tariff schedule for general  
and specialist services will be





Drewry

10252

provided by other carriers or provided under Workmen's Compensation or under any government or welfare auspices.

(d) Additional benefits, not part of the Standard Plan, might be added at an increased cost to cover ancillary services prescribed by a physician such as drugs, nursing service, physiotherapy, appliances and optical services.

If a person wishes to buy insurance limited to the benefits described in section (b)(i) above he may do so. That is in-hospital benefits, can be bought alone if someone did not want the whole coverage. This coverage is called the In-Hospital Plan.

In selecting the illustrative figures and percentages for deductibles and co-insurance, the Association has kept clearly in mind the economies which can result from the exclusion of readily budgetable items, while at the same time recognizing the importance of keeping those figures and percentages within manageable proportions for families of modest income.

The benefits set forth above will be provided by policies guaranteed renewable while the plan here described continues in effect.

Of course insurance companies will, as they have in the past, continue to strive to offer ever broader coverages on both group and individual contracts and to increase the numbers covered. Toward this end the insurance companies will continue to offer a wide variety of plans and to experiment with new





Drewry 10253

coverages. This will give Canadians the widest possible freedom of choice as to plan and insurer, and will continue the benefits that accrue to the insuring public from the competition among insurers to provide more attractive benefits and better service at lower cost.

4. WHAT WILL IT COST TO OBTAIN THIS COVERAGE?

To ensure that each individual will get his coverage at the lowest possible cost, the plan provides that each insurance company will determine its own premium rates on a competitive basis. The natural forces of competition will result in each carrier striving to provide the best service at the least possible cost. The proposed plan puts a maximum limit on the premium that may be charged to anyone.

It is believed that for this illustrative plan the maximum premium could be set at \$5.50 per month for each adult, and \$3.30 per child, with some overall limit per family. It should be emphasized that these are maximum premiums to apply only to individuals and families who for health or other reasons could not secure insurance in the normal way at lower rates. In other words, the present voluntary approach would be continued, with the added proviso that anyone who presently cannot secure this coverage would be assured that he could do so at a reasonable rate. To give some idea of the relationship between the suggested maximum premiums and standard premiums, it should be noted that the benefits of the illustrative plan might be made available to individual younger adult lives at premiums in the neighbourhood of \$2.50 per month.







Drewry 10254

5. Method of Sharing Excess Medical Care Costs -

A central reinsurance agency will be formed so that the excess medical care costs of those people insured at the maximum premiums can be equitably shared among all those insured for medical care costs. This would require legislation. Because of the pioneering nature of the proposed plan, some provision for amending or terminating the plan would be required in order to protect the regular policyholders in the event that the plan does not work satisfactorily. It is suggested that the position might be reviewed at the end of three years, or earlier if a broad base, say 60% of the residents, is not obtained.

Regardless of age, condition of health, occupation or geographic location, everyone who applies for a Standard Policy will receive identical policies, and these policies will be administered by the insurer of their choice in exactly the same way as all its other policies. However, the financial experience of those Standard Policies for which the stipulated maximum premiums are charged, may be reinsured by the original insurer with the central reinsurance agency. At the end of each year, the losses incurred by the central reinsurance agency will be allocated among all carriers in proportion to the number of individuals insured by each carrier (both under group and individual policies) and not reinsured by it in the central reinsurance agency.

In order to provide a broader and more equitable base for the sharing of these excess costs, the plan requires that all providers of medical care coverage



...the first thing I saw when I got up...

...to find the house empty and dark as usual. I went to the kitchen and found the door open. I went in and found the door open.

This would require investigation. I went to the police station and reported the matter. The police went to the house and found the door open.

In examining the plan would be found to be correct. I went to the police station and reported the matter. The police went to the house and found the door open.

...the door was open. I went to the police station and reported the matter. The police went to the house and found the door open.

...the door was open. I went to the police station and reported the matter. The police went to the house and found the door open.

...the door was open. I went to the police station and reported the matter. The police went to the house and found the door open.

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Drewry 10255

share in this allocation. This includes plans self-administered by an employer for his employees, employee association plans, union welfare plans, or any similar program. Were these plans not to be included in the allocation of excess costs, the costs for the healthy lives electing to be insured by the insurance companies would be higher than would be the corresponding cost in these so-called non-insured groups. This could result in individuals selecting the non-insured group to avoid these extra costs and thus escape bearing their fair share of the costs of extending the benefits of voluntary insurance to the substandard and uninsurable lives.

We understand that the doctor-sponsored prepayment plans presently have various arrangements for offering coverage to substandard lives. We believe that provisions could be worked out for including such plans in the same central reinsurance agency or, if they prefer, they might wish to set up a central reinsurance agency of their own.

MR. DREWRY: Now, the advantages are set forth, Mr. Chairman, in Section B of the main body of our submission. I think that Mr. Fitzhugh has really covered most of the points and perhaps it is not necessary for me to read it. Would you like me to read them, Mr. Chairman? It won't take very long?

THE CHAIRMAN: What page?

MR. DREWRY: Page 9.

THE CHAIRMAN: It's entirely in your own discretion. I think it would be very helpful if you would read it.





1  
2 MR. DREWRY: I will be delighted to  
3 read it. These are headed advantages of the Plan for the  
4 Extension of Medical Care Insurance.

5 2. The proposed plan for the extension of  
6 medical care insurance adds substantially to the many  
7 advantages which the voluntary system has over any compul-  
8 sory, government plan. It thus benefits the individual,  
9 the medical profession, the government and the country as  
a whole.

10 3. Among the principal advantages are the  
11 following:

12 (1) Medical care insurance to cover the bulk of  
13 the important cost that most frequently occurs  
14 will be made available to everyone who can pay  
15 the premiums, but no one will be compelled to  
buy it.

16 (2) Our proposals leave to the government the acti-  
17 vities that are generally considered to be a  
18 part of governments' role; for example, aid  
19 to those who are unable to provide completely  
20 for their own needs.

21 (3) Our proposals solve the problem of the health  
22 insurance needs of the nation without requir-  
ing any government contribution.

23 I think perhaps I should interject  
24 that it does not require any government contribution, but  
25 if the government, in its wisdom, decided to do something,  
26 say, for the marginal group which is being discussed with  
27 you, this mechanism would work with that kind of a system.

28 Consequently, serious political and economic  
29 problems for present and future generations  
30 are avoided. Under these proposals large and



of the... will be...

...these are the chief advantages of the plan...

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Drewry 10257

constantly increasing commitments for health care will not become a taxation problem for future governments and eventually a fiscal nightmare.

(4) The proposed CHIA plan makes use of the market place where the individual may exercise his right of free choice to buy or not to buy; and, if to buy, what to buy. Thus it does not compel everyone to accept exactly the same arrangements to provide for health care. At the same time, for those to whom the expenditure of even a relatively very small sum is a matter of concern, it provides a standard policy at a rate which no insurer may exceed, but which because of the competitive element, some insurers may reduce.

(5) Other traditional advantages of a competitive over a monopolistic system are preserved. These include better service, flexibility, a wider variety of coverages and the freedom of the purchaser to "shop around" for the best bargain he can make.

(6) The extremely personal relationship of doctor and patient is protected by preventing any agency from influencing or controlling the freedom of the individual to choose his doctor and of the doctor to accept or decline his patient. The necessity for such control has traditionally arisen under compulsory government plans.







Drewry 10258

(7) It is much safer for the economy of Canada to have many people making individual decisions on health insurance in the market place than to have a few people making far-reaching public decisions on such matters. The long-range effects of legislation required to implement a compulsory plan are impossible to foretell. The possibility of qualitative and quantitative deterioration of health care services should not be overlooked.

(8) No participation by government is required, either financial or otherwise, except in the legislation required to set up the central reinsurance agency and the possible remission of taxes on the premiums payable for medical care insurance under accident and sickness policies.

(9) The extension of medical care insurance will pave the way for the widest activity in the individual field by member companies, including major companies not now active in this area. This intensified activity means a rapid spread of coverage as the agency forces of the companies bring it to the attention of the public. In fact, the life insurance agents, through The Life Underwriters Association of Canada, have already indicated their endorsement in principle and pledged their support to the achievement of this objective (see Appendix VI).





Drewry 10259

There is included in the submission, Mr. Chairman, a copy of a letter from the Life Underwriters Association which you will find it Appendix VI.

THE CHAIRMAN: Thank you very much, Mr. Drewry. I have no doubt in this endorsement, and suggested premium rate that you tried to give consideration to the underwriting factors that will be involved. That appears to be set out in your Appendix II on Page 3 where we are dealing with the coverage. Particularly in Paragraph B, Sub-paragraph 1 and 2. Sub-paragraph 1 you deal with the certified specialists which would be an additional reimbursement up to 50% of the excess of the fee provided for in the tariff for a certified specialist over that for a general practitioner.

Are you able to say what you have in mind in that regard? That it would only be when the patient was referred by a general practitioner to a certified specialist?

MR. DREWRY: Can I pass that question to Mr. Fitzhugh. He is the expert?

MR. FITZHUGH: I don't want to keep passing the buck, but I would like to make a short statement. I would ask Dr. Emmett if he would like to amplify it.

Frankly, we had considerable discussion of this point and we were a little confused by the fact that our friends, the doctors, do not seem to have given a decision themselves as to whether ----

THE CHAIRMAN: That is why it is necessary we put the question to you.







Fitzhugh 10260

MR. FITZHUGH: We came back to our fundamental principle of some kind of co-insurance is necessary where there is a voluntary, optional feature in the plan and that is why we have co-insurance outside of the hospital.

If a man is in the hospital and has his doctor there, he is not going there unless he really has to. There is no occasion for this co-insurance, but when he has a choice, as he does in many cases ---

THE CHAIRMAN: We are only talking about an in-patient?

MR. FITZHUGH: Even in the hospital he has a choice as to whether to call in a specialist. We debated whether he will pay the full fee to the doctor when the patient is referred by a general practitioner to a specialist and not pay him at all. It seemed to us this was a practical way of avoiding the debate, the argument, but as we indicated in the whole plan, it is illustrative, and we think this is primarily a decision for the doctor, and if they decide it should be done another way, we can easily write the plan the way they feel it would be the best way and handle it from the Medical Association's point of view. We had to decide one way or another the type of plan to put in. We decided it this way. If they were referred, if less than half of them are referred, of course, it would be less to pay half of the extra, in every case. In other words, if only 30% of the ones calling for specialists were referred by the general practitioner the cost of paying the full amount of the referred cost would be less than paying half of the premium. Could go one way or another.







Fitzhugh

10261

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4 MR. FITZHUGH: We don't think that  
5 is really the decision for the insurance companies to  
6 make. We for practical purposes, and in effect have  
7 passed the buck to the doctors as to what is the best  
8 way to decide this question.

9 DR. EMMETT: I think the only thing  
10 I could add to that to clarify your thinking, as  
11 you indicated earlier for any one or all of the ten  
12 provinces the schedules in each province vary. Some  
13 provinces don't have a differential schedule of fees,  
14 others such as Ontario do. We had to take cognizance  
15 in our thinking of a method to fairly well look after  
16 the schedule of fees we were dealing with.

17 THE CHAIRMAN: This doesn't arise  
18 merely as an academic question. I think we have to  
19 recognize that there is a developing trend in medical  
20 practice by a direct approach. In the paediatrics field,  
21 that is almost universal, the need of a specialist.  
22 Does your proposal as you put it forward this morning  
23 automatically cut the recovery of 50% of every parent  
24 that takes his children directly to the paediatrician?

25 MR. FITZHUGH: Only if the difference  
26 between -- in the case of a paediatrician I don't think  
27 there is much of a difference. I haven't got all the  
28 figures in my head.

29 DR. EMMETT: Could we use a theoretical  
30 example of an appendectomy. I wouldn't even vouch for  
the accuracy of these figures.

THE CHAIRMAN: This is in hospital  
as Mr. McCutcheon has drawn to my attention.





Fitzhugh

10262

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4 DR. EMMETT: If an apendectomy is  
5 done by a specialist in the province where a differential  
6 schedule of fees is allowed he might well charge  
7 \$120.00. A physician without a degree would charge  
8 \$100.00 and in this instance we would pay \$110.00. It  
9 is 50% of the differential of the published fee  
10 schedule, not 50% of the specialist's fee, sir.

11 THE CHAIRMAN: I go back to three,  
12 benefits. Under 3(a) the plan provides insurance for  
13 the expenses of physical and medical services et cetera,  
14 et cetera, for physical and medical services the benefits  
15 are based upon the regular and customary fees for the  
16 necessary services. By that do you mean the general  
17 practitioner or the specialist? Is there any  
18 differential there. If there is none my question is  
19 perhaps pointless.

20 DR. EMMETT: There is none.

21 THE CHAIRMAN: Thank you very much.

22 COMMISSIONER BALTZAN: I didn't get  
23 that answer.

24 DR. EMMETT: I am sorry, may I ask  
25 you to repeat the question.

26 THE CHAIRMAN: 3(a), you are talking  
27 about benefits.

28 DR. EMMETT: Yes.

29 THE CHAIRMAN: You say you will insure  
30 to cover the expenses of the physical and medical  
services based upon the regular and customary fees  
promulgated by the province in which the policy is  
issued. Are you talking there of the general tariff or







Emmett

10263

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3 of the general tariff and the specialists' tariff?

4 DR. EMMETT: The tariff as published  
5 in the province, sir.

6 MR. FITZHUGH: It is modified by one  
7 or two.

8 MR. REID: That is what I was trying  
9 to point out the general statements in paragraph 3 are  
10 more defined in the following pages.

11 COMMISSIONER McCUTCHEON: Maybe this  
12 will qualify what the Chairman had in mind. Is it not  
13 the fact the only place you would differentiate between  
14 the specialist and the general practitioner insofar as  
15 not including additional co-insurance charge is when  
16 in hospital benefits. On out-hospital benefits -- if I  
17 go to the physician whether he is a general practitioner  
18 or specialist you pay the same percentage of his fee  
19 according to the tariff and if there is a differential  
20 you pay 80% of the fee.

21 MR. FITZHUGH: I think I am beginning  
22 to understand the problem. I am afraid we were really  
23 confusing the way we put it. There is no co-insurance  
24 in the hospital. For a general practitioner's fee out  
25 of the hospital we pay 80% co-insurance so we don't have  
26 any additional co-insurance. For the difference between  
27 the specialist and the general practitioner outside you  
28 are paying the 80% because you are paying 80% of the  
29 basic and 80% of the total.

30 What we are doing, in short, how we  
got 50 -- we looked at the Ontario schedule of fees and  
it so happens the general practitioner's fee plus 50%







Emmett

10264

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4 of the difference is just about equal to 80% of the  
5 specialist's fee. In the case of the specialist we pay  
6 80%, speaking generally, in our out of hospital. The  
7 general practitioner, we pay 100% in the hospital and  
8 80% out of the hospital.

9 I would like to make another general  
10 statement, sir, to emphasize that we put this in an  
11 illustrative way as the insurance companies had to sit  
12 down and come up with something.

13 THE CHAIRMAN: The underwriting  
14 procedure involved.

15 MR. FITZHUGH: If this plan were to  
16 be developed and became legislation we would expect to  
17 sit down with all interested parties, doctors, legislators  
18 and insurance actuaries and everybody else and come  
19 to a plan that met everybody's needs as best possible.  
20 In the absence of the opportunity to sit down with  
21 everybody we came up with an illustrative plan and it  
22 doesn't make much difference whether you do it one way  
23 or the other as far as this purpose is concerned. We  
24 realize in the final analysis it makes a great deal  
25 of difference.

26 THE CHAIRMAN: Then to come to sub-  
27 paragraph 2, I take you made a policy decision there  
28 in respect to psychiatric care, limiting the benefits  
29 allowed, 80% in general practice and 50% in psychiatric  
30 care?

MR. FITZHUGH: We made that, sir,  
for two reasons. In the first place our experience  
with policies we now have in existence, of course, for





Fitzhugh

10265

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3 obvious reasons it is a difficult one to control over-  
4 use, if you like. Those are the very patients that might  
5 over-use the specialist if they didn't have their own  
6 bills to pay. We also were advised by some doctors in  
7 that area, in that particular field, that it was doubly  
8 important for medical reasons to have a fairly large  
9 co-insurance feature there because in psychiatric  
10 treatment if the patient has a financial stake, if he  
11 knows it is costing him money, -- it is not the question  
12 of over-use -- he gets better therapy. I should turn  
13 this over to Dr. Emmett because we discussed this.  
14 It is better therapeutically for the patient to pay  
15 some money.

15 THE CHAIRMAN: I don't know. Maybe  
16 the people giving you that advice ought to consult a  
17 psychiatrist. It doesn't make sense to a layman.

18 MR. FITZHUGH: That is something that  
19 could be changed.

20 DR. EMMETT: We have talked to  
21 some psychiatrists in this field. In the straight life  
22 area where we have term or disability insurance we were  
23 advised by the consultant psychiatrists that if a certain  
24 replacement of income were not available the patient  
25 would improve more rapidly. It is as Mr. Fitzhugh said  
26 the other reason for having 50% co-insurance feature.

26 THE CHAIRMAN: Not treating psychiatric  
27 care differently from other medical care -- is this  
28 simply an outgrowth, a continuation of the age old  
29 prejudice against mental care? I am just wondering if  
30 you allowed for the inherent prejudice against the whole







Fitzhugh

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4 concept to be carried into insurance because if I may  
5 put it this way: We are being told a completely new  
6 and correct concept of mental illness is it is an  
7 illness which is like a physical illness, a broken arm  
8 or anything else and therefore that there ought to be  
9 from the standpoint, not only of a psychological  
10 approach but every other approach, there ought not to  
11 be any form of discrimination, no hospital out in the  
12 bush, that kind of thing nothing in an insurance  
13 policy that because I may require help in a mental  
14 way that I don't have the same rights as my neighbour  
15 who has to have a leg fixed or something like that.

16 MR. WATSON: Mr. Chairman, may I  
17 make a comment on that? There are two types

18 THE CHAIRMAN: I appreciate there  
19 is an underwriting proposition involved that means a  
20 higher premium.

21 MR. WATSON: I want to bring out  
22 another point sir.

23 THE CHAIRMAN: Is this not the fact of  
24 trying to keep the premium down by continuing  
25 the discrimination that has gone on in terms of mental  
26 illness?

27 MR. WATSON: I want to make the point  
28 there is in these days in psychiatry a tendency of  
29 treating people who are not really mentally ill, but  
30 have some disturbance at home. In the old days they  
would have gone to the minister or the priest for advice,  
and today there is a trend to seek the solution to  
marital problems. It is an attempt to make a distinction







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4 between real mental illness and supposed mental  
5 disturbances that we get into the larger co-insurance  
6 feature. That is an important factor.

7 THE CHAIRMAN: Who makes that distinction?

8 MR. FITZHUGH: That was our difficulty.

9 THE CHAIRMAN: Isn't a person who  
10 feels he has to consult a psychiatrist -- that is an  
11 illness. The mere fact that I have a pain in my  
12 stomach, that is what takes me to the doctor. All  
13 right, if I have troubles I go to a doctor.

14 MR. FITZHUGH: If I may, sir, come  
15 back to my general statement, we as insurance companies  
16 did the best we could to come up with an illustrative  
17 plan with the understanding that wiser heads than us  
18 in the medical field are going to make this final.

19 THE CHAIRMAN: I wouldn't accept  
20 this completely. There is nobody -- there ought to be  
21 nobody with a veto over anything.

22 MR. FITZHUGH: With discussion then.  
23 Maybe I ought not to have said wiser heads would make  
24 the decision. Wiser heads with more knowledge of this  
25 subject at the proper time would sit down and say this  
26 is the best way of handling it, the best way to treat  
27 it if you like, for this purpose.

28 THE CHAIRMAN: Have your companies  
29 any objections, any basic objections to treating mental  
30 illness as any other illness?

MR. FITZHUGH: We would just as well  
do it, sir, if the advice of the competent people was  
that that was the best thing for the patient. Our





Fitzhugh

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advice so far is that it isn't. If we haven't got the right advice we would be very glad to have different advice.

COMMISSIONER BALTZAN: May I interject just for a moment, referring to paragraph 2 on page 3 of your appendix, the subject that is now under discussion:

"For physicians' charges out of  
"hospital or while a patient is an  
"out-patient as a hospital benefits  
"will be 80% (50% for psychiatric  
"care) of the tariff charges."

The point I am going to raise here that brings into discussion the psychiatric care as a subject to be discriminated or separated from physical care. Instead of 50% of psychiatric care -- psychiatric care can be given by the attending physician, it is 50% of the psychiatric specialist's care that would be co-insurance?

DR. EMMETT: That is our intention, certainly. I agree that word should be inserted.

COMMISSIONER BALTZAN: That doesn't involve the discrimination factor. It doesn't separate mental illness from physical illness. Some have even told us 90% of the emotional counselling element is generally looked after by the family physician, and very competently.

MR. FITZHUGH: I think that would express it correctly.

THE CHAIRMAN: I am sorry, I think that only compounds the felony.







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Fitzhugh

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4 COMMISSIONER BALTZAN: I am only trying  
5 to help.

6 MR. FITZHUGH: That was our trouble.  
7 We got all kinds of different advice from different  
8 people. We had to get something specific. It just as  
9 well could have been decided the other way.

10 THE CHAIRMAN: If psychiatric care  
11 is going to be of consequence it ought to be, if it is  
12 available at all, then it ought to be specialist care  
13 that would be the most valuable.  
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Fitzhugh

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MR. FITZHUGH: For the premium there is no underwriting reason why we couldn't take out that parenthesis completely and have 80% for psychiatric. As underwriters we would query whether it is fair to charge everybody else that higher premium for the people who might over-use that privilege. As far as insurance is concerned, we are going to get the premium, but we are trying to get the premium for most of the people as low as is reasonable, but if that is a feature that is going to be in the plan we will put it in.

THE CHAIRMAN: You put it in for the very same reason as you carry the uninsurables. You say that everybody is able to pay a reasonable premium, regardless of age or condition, and then you go to this re-insurance fund that you speak of.

MR. FITZHUGH: It could be done, sir.

MR. REID: Mr. Hall, I think you would find, if you talk to some psychiatrists, that they themselves would welcome a pretty substantial deterrent. They really go crazy on the thing with some of the calls they get from some of their patients. If they think that everything is going to be paid for -- as a matter of fact, I have just gone through this myself. A pretty close relation of my family was calling the psychiatrist two or three times a day, sometimes at 3 or 4 o'clock in the morning. It could be awfully abused. I think the psychiatrists themselves generally would welcome a fairly substantial deterrent to over-utilization of their services.

THE CHAIRMAN: Well, I am not in a





Austin

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position to argue that point. I have no competency in the field. All I have is an element of common sense, I hope, but I think that anybody who is getting up at 4 o'clock in the morning believes that they have a problem.

MR. AUSTIN: Mr. Reid, cannot we state categorically that whatever the reasons for this, none of them indicate any prejudice on our part as to mental illness? There is no discrimination.

COMMISSIONER McCUTCHEON: As Mr. Fitzhugh says, you can underwrite it if that is the desirable thing to do?

MR. FITZHUGH: That is right.

THE CHAIRMAN: Because of the sociological idea involved of coverage being available to the greater number of people, or to all.

MR. FITZHUGH: If they are really in trouble they are in the hospital, and then there is no 50%.

MR. REID: There is no co-insurance at all.

THE CHAIRMAN: There is no co-insurance now when they are in the hospital out in the bush, but nobody is satisfied with that.

I just want to come to your central re-insurance agency. Your proposition here is to cover the uninsurables in a common pool, and as an industry to attempt in that way to give the coverage. A plan of this kind naturally is available only to someone who can pay a reasonable premium?







Reid 10271

MR. REID: Yes, sir.

THE CHAIRMAN: What consideration were you able to give to the possible inclusion in such a plan of those for whom a premium might be paid, or to a class in which there might be a subsidizing of the premium?

MR. FITZHUGH: We considered that at some length, sir, and decided that it would be presumptuous, that is a good word, to suggest a subsidy here, because we are talking as voluntary insurers making it available to anybody who can afford to pay the premium.

Again speaking as insurers, and I am trying to choose my words carefully, but I am sure you will understand what we mean; all we need is the premium. The source of the premium, as insurers, is not too important. We don't want any subsidy from the Government. We want this to run on its own, but if the Government feels there is a certain class whose incomes are too low to afford the premium, and they pay the premium for them, that is between the Government and the individual, and is not a direct concern of an insurance company as an insurance company.

If the Government decided to pay the premiums for the indigent class, if you like, they could be put in the plan just like anybody else. Or, if the Government said that people under a certain class they would pay the whole premium, at another income level the Government would pay half the premium, that then would be between the Government and the individual. If the individual couldn't afford to pay the premium he







Fitzhugh

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would apply to the Government and the Government would say yes, under certain rules you are qualified, here is a voucher and he would go to the company with the voucher.

THE CHAIRMAN: There is no reason why that might not be done by the insurance companies, the industry, as you call it, as well as by the doctor-sponsored plan?

MR. FITZHUGH: We see no reason why it couldn't be done either way, and as you know, the doctor-sponsored plans are doing it now to a considerable extent, and if the Government asked the insurance companies to participate in that kind of proposition, we would be glad to do so, but we didn't think it was up to us to do that.

THE CHAIRMAN: When you use the word "government" ---

MR. FITZHUGH: Any government.

MR. REID: I would like to emphasize that we do not want the subsidy paid to us. If they want to subsidize the individual, fine.

THE CHAIRMAN: Therefore what would your attitude be to a proposal that it would be a government subsidy to the central re-insuring agency, to keep the premium at a level that many more would be able to pay it, than this proposal of yours now to those who can pay this projected premium, whatever it might be?

MR. FITZHUGH: We think it is a fundamental difference. We would prefer not to have a subsidy to the pool, but again, if the Government wants to say





Fitzhugh

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4 that anybody who we would put into this pool and charge  
5 \$5.50, if the Government says we will pay \$2.50 of that,  
6 or any other figure, for the individual, that again is  
7 fine with us, but we do not feel that it is advisable  
8 for the Government to directly pay a million dollars,  
9 or any other figure, directly to the central pool, but  
10 if they want to arrange it that the cost of getting into  
11 the pool is not \$5 or \$4 or any other figure, and they  
12 will make up the premium payment, that is all right.

13 THE CHAIRMAN: Did you discuss with  
14 Mr. Kilgour the proposal which the Government of Manitoba  
15 put forward, which is, in effect, that the Government of  
16 Manitoba, for the people of Manitoba, would subsidize  
17 the premium, so as to bring it down to the level to make  
18 it available to everybody in the province?

19 MR. FITZHUGH: I cannot quote Mr.  
20 Kilgour.

21 THE CHAIRMAN: And they were discussing  
22 that in terms of the doctor-sponsored, non-profit plan.

23 MR. FITZHUGH: That is right, I remember  
24 a proposal in Manitoba.

25 THE CHAIRMAN: I am asking you whether  
26 if such a proposal should find acceptance in any quarter,  
27 whether the insurance industry could participate in such  
28 a thing, as well as the doctor-sponsored plan?

29 MR. FITZHUGH: If the Government so  
30 decided, sir, we could participate. We have approached  
this plan, as far as this central re-insurance agency is  
concerned, that anybody who can afford the \$5.50 as an  
individual should pay it. If he does not need assistance



that anybody who we would put into that pool and charge \$5.00, if the Government says we will pay \$1.50 or more, or any other figure, for the individual, that is all right with us, but we do not feel that it is desirable for the Government to directly pay a million dollars, or any other figure, directly to the central pool, but if they want to arrange it that the cost of getting into the pool is not \$5 or \$4 or any other figure, and they will make up the premium payment, that is all right.

THE CHAIRMAN: Did you disagree with Mr. Kilgour the proposal which the Government of Manitoba put forward, which is, in effect, that the Government of Manitoba, for the people of Manitoba, would subsidize the premium, so as to bring it down to the level to make it available to everybody in the province?

MR. FITZGERALD: I cannot quote Mr. Kilgour.

THE CHAIRMAN: And they were discussing that in terms of the doctor-sponsored, non-profit plan.

MR. FITZGERALD: That is right, I remember a proposal in Manitoba.

THE CHAIRMAN: I am asking you whether if such a proposal should find acceptance in any district, whether the insurance industry could participate in such a thing, as well as the doctor-sponsored plan?

MR. FITZGERALD: If the Government decided, sir, we could participate. We have approached this plan, as far as this central re-insurance agency is concerned, that anybody who can afford the \$5.00 as an individual should pay it. It does not need assistance





Fitzhugh

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3 from the Government just because it happens to be \$5.50,  
4 if he has a good income, he does not need assistance  
5 from the Government.

6 That the Government's aid should not  
7 be to people just because the premium is high. It  
8 should be to people who cannot afford what the premium  
9 is, but if the Government decided it wanted to help  
10 everybody who had to pay \$5.50, regardless of their  
11 income, that is between government and individuals again,  
12 and we could operate on that program if it was so  
decided.

13 MR. WATSON: Of course, there would be  
14 some indigents who would not be in the pool at all.

15 MR. FITZHUGH: If they could afford  
16 \$5.50, then whether the Government should contribute  
17 anything because \$5.50 sounds high, that is a different  
question.

18 THE CHAIRMAN: This premium runs at  
19 roughly \$200 a year for a man and his wife and two  
20 children.

21 MR. FITZHUGH: Assuming they are all  
22 bad risks. It would be an unusual family to be all at  
23 the maximum premium. It is a conceivable situation,  
24 but there wouldn't be more than half-a-dozen families  
25 in Canada probably paying that maximum premium.

26 MR. MORRISON: In discussions with the  
27 Premier in Manitoba on this program, we certainly stand  
28 ready to participate in this plan through assistance  
29 from government. We do, though, feel that such subsidy  
30 should be made to the individual, and I think there are



from the Government just because it happens to be \$5.50.  
if he has a good income, he does not need assistance  
from the Government.  
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should be to people who cannot afford what the program  
is, but if the Government decided it wanted to help  
everybody who had to pay \$5.50, regardless of their  
income, that is between government and individuals again,  
and we could operate on that program if it was so  
decided.

MR. WATSON: Of course, there would be  
some indigents who would not be in the pool at all.  
MR. FITZBUSH: If they could afford  
\$5.50, then whether the Government should contribute  
anything because \$5.50 sounds high, that is a different

THE CHAIRMAN: This premium runs at  
roughly \$100 a year for a man and his wife and two  
children.

MR. FITZBUSH: Assuming they are all  
bad risks. It would be an unusual family to be all at  
the maximum premium. It is a conceivable situation,  
but there wouldn't be more than half-a-dozen families  
in Canada probably paying that maximum premium.

MR. MORRISON: In discussions with the  
Premier in Montreal on this program, we certainly are  
ready to participate in this plan through assistance  
from government. We do, though, feel that such assistance  
should be made to the individual, and I think there are



Morrison

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many practical ways in which it can be made to the individual. That authorization would be made to the company, but we would prefer certainly that this be a subsidy of the individual, rather than directly of the company.

THE CHAIRMAN: Well, thank you very much, gentlemen. These are some of the points that I thought I would like to have a discussion on this morning.

COMMISSIONER FIRESTONE: Mr. Reid, I would like to thank you first of all for providing us with the information that was suggested to you and your associates in Halifax. You have been very helpful to us, both in this brief and Mr. Fitzhugh and Mr. Kilgour and their associates in Ottawa, and in the additional information which you have or are making available to our research staff. We are very grateful to you and your associates for having done that.

In paragraph 2 of your summary and recommendations, on page 1, you speak of approximately 10 million people having coverage under the present voluntary system of health insurance. Mr. Reid, I am addressing the questions to you. Please feel free to have any of your associates answer as you see fit.

Do we know how much the health insurance industry has paid out in the last year for such health costs, for which arrangements are in existence under the prepayment schemes administered by various health insurance groups in Canada?

MR. WATSON: We have, in our Appendix,





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THE CHAIRMAN: Well, thank you very much, gentlemen. These are some of the points that I thought I would like to have a discussion on this

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Do we know how much the health insurance industry has paid out in the last year for such health costs, for which arrangements are in existence under the present schemes administered by various health insurance groups in Canada?

THE CHAIRMAN: We have, in our Appendix,





Watson

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the figures for 1960. Those are the only figures that are readily available. If you turn to Appendix III.

MR. DREWRY: That only covers our industry. It does not cover the prepaid plan.

COMMISSIONER FIRESTONE: Well, what is the figure that you would like to give us, sir?

MR. WATSON: First of all, I was referring you to Appendix III, on page 3, and that gives you the figure for our industry. I will see if I can find the total figure in a moment. You will see there at the bottom of the page that the benefit payments in 1960 were \$118,617,000 for all lines of accident and sickness, not just medical.





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COMMISSIONER FIRESTONE: Now, this \$118 million, does that cover health benefits only?

MR. WATSON: Health and accident, that has accident and sickness benefits.

MR. DREWRY: And income.

MR. WATSON: Perhaps I should clarify: It covers weekly income benefits. It covers accident, what we call accident benefits, A, D and D, hospital medical, surgical, major medical, miscellaneous benefits, all that kind of health benefits but also what we call accident and sickness benefits.

COMMISSIONER FIRESTONE: Well now, have you a separate figure to show health benefits only as distinct from sickness and the other benefits? The reason is I am looking as to what portion of total health cost in Canada is covered through prepayment.

MR. WATSON: For 1960 I have some additional figures here. This is the survey of voluntary health insurance in Canada and it is for group insurance only. I have hospital expense at \$24 million, surgical expense \$19 million, medical expense \$8.7 million, comprehensive major medical \$16.9 million and that gives a total of approximately \$69 million.

COMMISSIONER FIRESTONE: Now that covers group?

MR. WATSON: That covers group.

COMMISSIONER FIRESTONE: How much do we have to add to cover individual?

MR. WATSON: Approximately \$8.5 million giving a total of \$77.4 million. Those are the insurance companies only, we do not have the figures

COMMISSIONER FIRSTONE: Yes, this

250 million does that cover health benefits only

MR. WATSON: Health and accident,

that has accident and sickness benefits,

MR. WATSON: And income,

MR. WATSON: Because I should mention

it covers weekly income benefits. It covers accident,

what we call constant benefits, A, B and C, hospital

all that kind of health benefits but also what we call

have you a separate figure to show health benefits only

as distinct from sickness and the other benefits? The

reason is I am looking at to what portion of total

health cost in Canada is covered through employment.

MR. WATSON: For 1960 I have some

additional figures here. This is the survey of voluntary

health insurance in Canada and it is for group insurance

only. I have hospital expense at \$45 million, sickness

expense \$12 million, medical expense \$8.7 million,

comprehensive major medical \$16.9 million and that gives

a total of approximately \$99.5 million.

COMMISSIONER FIRSTONE: How does

cover group?

MR. WATSON: That covers group.

COMMISSIONER FIRSTONE: And what is

we have to add to cover individuals?

MR. WATSON: Approximately \$1.1 billion

giving a total of \$100.6 million. Those are the

insurance companies only, we do not have the figures





Watson

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4 for the prepayment plan.

5 COMMISSIONER FIRESTONE: Prepayment  
6 plans or doctor-sponsored groups?

7 MR. WATSON: We do not have those  
8 figures.

9 THE CHAIRMAN: Or the employees.

10 COMMISSIONER McCUTCHEON: Appendix 3  
11 seems to be only 21 companies, that might be the total  
12 premium income but not the total for the industry?

13 MR. WATSON: Those are just the  
14 companies. I do not have the figures available but the  
15 figure you have asked for is \$77.4 million.

16 COMMISSIONER FIRESTONE: \$77.4 million  
17 and that covers medical and other health costs paid  
18 out in 1960 by insurance companies in Canada, commercial  
19 carriers in the health field, is that right?

20 MR. DREWRY: If I may interject, I  
21 believe we are discussing with Dr. Berry of the  
22 Commission's research staff a questionnaire and my  
23 recollection is that this same question is included  
24 in the questionnaire. We are endeavouring to supply  
25 the information that is needed.

26 COMMISSIONER FIRESTONE: You have  
27 been very helpful and we are very grateful to you.  
28 Just for discussion here we would like to look at the  
29 role of the health insurance industry in the medical  
30 care field based on the figures which you have supplied  
us. It appears you may be covering somewhere between  
15% to 20% of the total medical care cost in Canada.  
We were given a figure yesterday by the Canadian Medical





Watson

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4 Association of between \$350 million and \$400 million  
5 which would work out somewhere between 15% and 20%,  
6 more likely to 20% than 15% but something of that order.  
7 Would you feel that this reflects reasonably the role  
8 of the commercial carriers in the field of prepayment  
and health costs at the moment?

9 MR. WATSON: Well, these figures are  
10 for particular plans of benefits that we are currently  
11 selling and if we look to a general plan that would be  
12 more comprehensive then, of course, the premium -- the  
13 claim volume would be much higher. It is very difficult  
14 to relate what we are doing now to what could be done  
under a general plan.

15 COMMISSIONER FIRESTONE: You are  
16 reading my mind, I am trying to establish where you  
17 would go from here. We have established the basis that  
18 you are covering something between 15% to 20% of medical  
19 care costs in Canada through policies made available  
20 by commercial carriers. Now you have come to us and say  
21 "We realize this perhaps is not quite an adequate  
22 coverage, we can do more or do better. We have a new  
23 plan to suggest." And now the question I would like to  
24 put to you, assuming that a new plan is introduced, what  
25 do you think you might be able to achieve in terms of  
26 the coverage through prepayment of total medical care  
27 cases because this is the proposal that has been put  
28 before us, we pay so much on medical care costs and we  
29 want to have it covered through prepayment. We have  
30 a comprehensive plan before us, what would be the result  
of the plan in terms of the proportion of outside medical







Watson

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care costs on Canadians to be covered assuming the plan would be introduced along the line you have suggested. Of course, it would take a few years, you cannot achieve miracles overnight, it would take a few years to mature but what would be the objective?

MR. WATSON: There are a number of points must be considered in that event. Number one, we are talking of a voluntary plan and, therefore, there will be some people who will not join in any event so that possibly 15% or even more may not elect. We, first of all, take the group out that cannot. Secondly we have certain co-insurance factors to be taken into account and what that will amount to we cannot say but it might possibly amount to 20% so, again, we must add that in. Thirdly, there are some sections of the population we cannot reach by virtue of indigency and that might account for 5% or 10% depending on where the line is drawn and this has to be added in as well. I just want to bring out these factors to indicate that we cannot possibly get any substantial percentage through if we are -- your figure of 30%, was that the percentage you used? If we take 30% --

COMMISSIONER FIRESTONE: We would assume between 15% and 20% at present and the question is, what would happen, what would you be able to achieve in terms of increased coverage on medical care cost as the result of the plan after they have been given the chance to mature.

MR. WATSON: If we had 20% now, by increasing the coverage we might raise it to 30%, possibly,





Watson

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4 and by extending coverage to a greater volume of people  
5 I think we might increase it by another 50%. I think  
6 we might possibly get the 50%. Perhaps one of my  
7 colleagues might like to speak to that.

8 MR. FITZHUGH: I would like to comment  
9 on that. There are two factors involved, first, what  
10 percentage of the people of Canada would have coverage  
11 and, second, what percentage of their medical bills  
12 would be covered. I would like to take the two separately.  
13 Also, from the point of view of the country and the  
14 people in the country it is more important how many of  
15 these will be covered by the various plans rather than  
16 just the insurance companies so right now is compared  
17 with your 15% to 20% of the medical bills covered by  
18 insurance companies you have at least an equal amount  
19 covered by the doctors' prepayment plan. Then you have  
20 the union welfare funds, employer plans, so there is  
21 a fair amount. I admit I do not know the per cent but  
22 we can get it for you what the percentage is now  
23 covered.

24 If we look at health coverage for  
25 all insurance companies, doctor prepayment plans,  
26 employer plans, our proposal does not say we want all  
27 the business. Using your statement that this plan  
28 must have time to mature and, again, I have to back up  
29 a bit and say it has slowed up recently because a lot  
30 of people are wondering what is happening. Assuming  
that this plan is adopted and there is publicity and  
the people come out and do what they are supposed to  
do, we should get well over 70% of the people covered,









Fitzhugh

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3 whether it is us or the prepayment plans I don't care  
4 as long as they are under some voluntary plan. As to  
5 the percentage of their bills covered, I think it is  
6 also necessary to consider what is included in this  
7 total medical bill. Included in the large figure are  
8 many thousands of \$4.00 doctors' bills for one visit  
9 to the doctor and I am not sure whether that figure  
10 you quoted includes anything but doctors' bills, I am  
11 not familiar with that.

12 MR. DREWRY: I think the figure is  
13 from the national accounts and that includes dentists.

14 MR. WATSON: \$381 million is medical  
15 and dental care.

16 MR. FITZHUGH: This plan does not  
17 cover dental, as we have proposed it so you have to take  
18 that out of the figures. We also think in our philosophy  
19 one should take out these \$4.00 and \$5.00 bills because  
20 we do not think there is any of these that were prepayment  
21 plan, in fact, it is uneconomic to include these bills.  
22 Of the people who are covered let us say we get 70%  
23 after a few years of the medical bills of these people,  
24 if we cut out these small bills this plan would cover  
25 all the bills in the hospital with the possible exception  
26 of those extra for specialists, 80% of their medical  
27 bills outside of the hospital and as half the bills are  
28 in the hospital by arithmetic we would probably cover  
29 something like 90% of the medical cost of the people  
30 to elect to come into the plan excluding these \$4.00  
items. Is that the kind of answer you want to the  
question?





Fitzhugh

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4 COMMISSIONER FIRESTONE: It is a  
5 very helpful answer. You appreciate there is demand in  
6 Canada for a comprehensive medical care plan and the  
7 way people look at medical care costs, they say "My  
8 doctor bills are so much, where do I get the money to  
9 pay for them?" Whether it is \$4.00 bills or \$200.00  
10 bills it is all part of the medical care cost. What  
11 you are saying is that if people are covered, not  
12 including these smaller payments, there would be a fairly  
13 good coverage up to 90% of actual cost. That statement  
14 might be qualified, for those that face catastrophic  
15 illness because you have placed an upper limit of  
16 \$5,000.00. Presumably those people would have to pay  
17 the additional cost out of their own pocket in those  
18 cases and the coverage might be considerably less than  
19 90%, is that right?

20 MR. FITZHUGH: On that one point again,  
21 that \$5,000.00 was illustrative when we are entering  
22 into a pretty new field we feel that we should have  
23 some control on it. We have suggested that the plan  
24 be reviewed at the end of three years. We would not  
25 expect that many people would have reached that \$5,000.00  
26 within three years. By that time we can see what the  
27 problem was, how many people are likely to go over that,  
28 whether it should be \$10,000.00 instead of \$5,000.00 but  
29 we do not think many people would run out of benefits.  
30 However, as a going-in start we suggested \$5,000.00  
with the idea that would be adjusted so not many people  
would run out of benefits.

COMMISSIONER FIRESTONE: I assume you







Fitzhugh

10284

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4 appreciate these people with catastrophic illness are  
5 the hardest hit and they need the help.

6 MR. FITZHUGH: We would hope -- we  
7 felt it was better to walk before we ran in putting in  
8 a plan and it is much better to raise the limit from  
9 \$5,000.00 to \$10,000.00 than take it back from \$10,000.00  
10 to \$5,000.00.

11 THE CHAIRMAN: There is the experience  
12 with the civil servant coverage. The ceiling has  
13 already been raised.

14 MR. FITZHUGH: And, incidentally, once  
15 they have been raised there would be procedure for  
16 reinstatement; if there was, as a result of an automobile  
17 accident and when he was all through he was as good as  
18 new he could start all over again. The reason for the  
19 maximum to start with, we wanted to see so far as the  
20 long term chronic cases which we grant are the ones that  
21 need it the most, we wanted to see what the area was  
22 before we plunged all the way in.

23 Coming back to your statement on what  
24 people want as coverage on all doctor bills including  
25 \$4.00 bills, half the people of Canada have elected  
26 the doctor-sponsored prepayment plans would pay, in  
27 general, these small bills and half have elected the  
28 insurance company plans that do not pay for it.  
29 Apparently at least half of the people feel they do not  
30 want to pay a premium for the privilege of having an  
insurance company pay back to them \$4.00 in claims anymore  
than they would for their telephone bill or electric  
light bill every month. This is a matter of choice and,

sympathize these people with osteoporosis illness.

The hardest bit and then read the bill.

MR. FITZGERALD: We would like to see

that it was better to wait before we had in 1977 in

a plan and it is much better to raise the family from

\$5,000.00 to \$10,000.00 that take it back from \$10,000.00

to \$5,000.00.

THE CHAIRMAN: There is the answer.

with the civil service coverage. The ceiling was

already been raised.

MR. FITZGERALD: And, incidentally, once

they have been raised there would be no more for

retirement; if there was, as a result of an automatic

adjustment and when it was all through he was as good as

new he could start all over again. The reason for the

decision to start with, we wanted to see as far as the

long term chronic cases which we grant are the ones that

need it the most, we wanted to see what the plan was

before we plunged all the way in.

Going back to your statement on that

people want as compared on all doctor bills including

\$5.00 bills, but the people of Canada have elected

the 50-cent-a-month and government plans would say, in

general, these bills are not all paid for by the

insurance company plans that we not pay for it

agreement, at least half of the people feel they do not

want to pay a premium for the privilege of having it.

Insurance company pay back to them \$10.00 a month and

that they would pay their telephone bill or electric

bill every month. This is a matter of choice and



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4 again, we feel they should have the privilege of  
5 electing a plan that has no deductible if they want it  
6 and the prepayment plans if they want to ask the  
7 privilege of a plan with small deductibles we think that  
8 is an advantage of a family plan; they could do it  
9 either way.



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4 COMMISSIONER FIRESTONE: Well, your  
5 reference to premium brings us to Paragraph 4 of Appendix  
6 II, Page 4, where you offer some suggestions as to the  
7 maximum premium that should be set for the plan which you  
8 have put before us. You have mentioned \$5.50 per month  
9 for each adult, \$3.30 per child, with some overall limit  
10 per family. Have you an overall limit per family in  
11 mind, sir?

12 MR. FITZHUGH: There was running in  
13 our mind \$20.00. But to add to my remarks earlier to  
14 the Chairman, we think it is going to be the rare family  
15 now who is going to pay for a wife and three or four  
16 children to get it up to \$20.00. But there would be a  
17 ceiling.

18 COMMISSIONER FIRESTONE: What would you  
19 consider under this plan as an average premium, not  
20 exceptional?

21 MR. FITZHUGH: Well, we indicated for  
22 a young adult it would be \$2.50 compared with \$5.50  
23 maximum.

24 MR. WATSON: That would be age 30,  
25 30 and 35.

26 MR. FITZHUGH: Now, what the maximum  
27 would be depends on what you elect to go into the plan.  
28 We would hope to get, say, age 40, would you say, Mr.  
29 Watson ----

30 MR. WATSON: 40 to 45 would be around  
\$3.00, \$3.25.

MR. FITZHUGH: It would be something  
around \$3.00.





Fitzhugh 10287

COMMISSIONER FIRESTONE: It would still  
be ---

MR. FITZHUGH: The average would still  
be \$2.00, the healthy ones.

COMMISSIONER FIRESTONE: Why would the  
average be less when the father is 40 years than when  
he is 30 years?

MR. WATSON: The maximum of \$3.30 is  
for a young healthy child. We are talking about the  
normal, and I think \$2.00 for the average child and an  
adult of 40 to 45, say, \$3.25.

COMMISSIONER FIRESTONE: In other words,  
it would be \$10.50 for a healthy family which has no  
serious pre-existing conditions, roughly?

MR. FITZHUGH: With two children, yes.

MR. WATSON: That is correct, sir.

COMMISSIONER FIRESTONE: And it would  
be \$12.50 with three children.

MR. WATSON: It depends on the age  
distribution.

COMMISSIONER FIRESTONE: A normal  
healthy family with children in their teens.

MR. REID: It would be the rare  
family, only one individual in the family.

COMMISSIONER FIRESTONE: We are trying  
to get the premium of the reasonably healthy family.  
There isn't such a thing as an average family, but that  
indicates to us what reasonably healthy people would have  
to pay.

MR. FITZHUGH: Between \$10.50 and \$12.50







Fitzhugh 10288

would be a good figure.

COMMISSIONER FIRESTONE: Do I understand from the answers you have given to us, gentlemen, that you are planning to determine premiums on an individual risk basis rather than averaging it by groups, by age or other categories?

MR. FITZHUGH: Here again, sir, our belief was that it is best to keep the competitive advantage of each company doing it in its own way as long as it doesn't charge anybody more. Group insurance is a flat rate, but on individual insurance some companies may elect to charge a community rate and other companies may charge a rate varying by age, others may charge a rate varying by sex. We think that each company trying to get the business at the lowest rate is the best plan for Canadians. Some may do it one way, some the other.

COMMISSIONER FIRESTONE: If a person is 65 years of age, married, two elderly people, what would their premium be?

MR. FITZHUGH: \$11.00. I would assume that both companies would charge the maximum.

COMMISSIONER FIRESTONE: It would be of that order?

MR. FITZHUGH: Yes, sir. If they are very healthy people, I am sure some company, if they would like that business, would do it for \$10.00.

THE CHAIRMAN: Would you have in mind a step rate?

MR. FITZHUGH: They might charge a premium at the age the man comes in and keep it at that





Fitzhugh 10289

level or it may go up each year. But it can never get above the \$5.50.

THE CHAIRMAN: If you have a step rate, it would go up all right.

MR. FITZHUGH: Yes, if you have the step rate they would pay the \$5.50.

COMMISSIONER FIRESTONE: Can coverage be discontinued?

MR. FITZHUGH: No, they can't under any circumstances discontinue coverage. Even if he puts a claim in every week he continues and it goes into the pool. No one company may feel they can do that, but as long as it is spread around there is no cancellation. When you pay the premium you are insured.

COMMISSIONER FIRESTONE: And there would be no exemptions for newly developing conditions. If somebody got a heart condition, there would be no exemptions.

MR. FITZHUGH: No riders, no tricks. If he gets a cancer condition, heart condition, diabetes condition, he is covered. When he comes in, if he lies to the company, if he says he is perfectly healthy and he gets the \$2.50 or \$3.00 rate and in two months he is in the hospital with something he had in the first place, then he will pay the \$5.50. He would get the coverage, but he wouldn't get it at the low rate. But he would be insured. It is only on misrepresentation, sir.

MR. WATSON: A concealment.

THE CHAIRMAN: The only effect concealment would have would be to reduce the rate.







Fitzhugh 10290

MR. FITZHUGH: Yes, the only incentive a man has to conceal something is to get it at the low rate.

COMMISSIONER FIRESTONE: In Paragraph 3(d) on top of Page 4 of Appendix II you suggest that this plan could also cover cost of "ancillary services prescribed by a physician such as drugs, nursing service, physiotherapy, appliances and optical services." Have you worked out a premium for the coverage of such ancillary services?

MR. FITZHUGH: We have lots of different premiums for lots of different ancillary coverages, sir.

COMMISSIONER FIRESTONE: So that we understand each other, I am not asking for a list of all the plans you have in operation, I am just asking for the extension of a plan which you have submitted to us for illustrative purposes. What would be the situation if that illustrative plan were extended to cover the items listed on top of Page 4, Appendix II?

MR. FITZHUGH: It depends what benefit you have for drugs, for nurses. But we do have one set worked out to fit an ancillary benefit.

COMMISSIONER FIRESTONE: What we are after is what you consider is appropriate on a proper corollary of the plan you put before us.

MR. WATSON: We have certain tentative ideas of the cost of adding a special nursing benefit and also benefit for drugs and prosthetic devices, but we wouldn't issue these separately, they would be part of the plan. What I am giving you now is the cost of including



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also benefit for drugs and prosthetic services, but we  
wouldn't issue these separately, they would be part of the  
plan. What I am giving you now is the cost of including



Watson 10291

them in the plan.

COMMISSIONER STRACHAN: What type of prosthetic device?

MR. WATSON: I haven't got the details here, but it would be crutches, iron lungs and things of that kind that we normally put in our major medical plans. There is no limit on the type. It says prosthetic devices that the physician recommends.

COMMISSIONER STRACHAN: That is an extremely common expression in dentistry.

MR. WATSON: For special nursing reimbursement will be equal to 80% of covered nursing expenses. Covered nursing expenses are all charges for services of registered graduate nurses, but only 75% thereof for services outside of a hospital.

Now, the premium for special nursing benefit is dependent upon the age and it ranges from 10¢ at the younger adult ages to 75¢ at the ages over 60. That is a monthly premium per individual. That is for special nursing.

Then, for the drugs it ranges from 50¢ at the younger adult ages to \$2.25 at ages 60 and over. So to have both these benefits combined, and these must be in addition to the basic plan, the premium would be monthly 60¢ at the young adult ages, ranging to \$3.00 at the higher ages, 60 and over.

On drugs there is 80% of the charges. There are certain conditions here which I am not reading out, but it is 80% for the nurses and 80% for the drugs.

THE CHAIRMAN: Do you mean 75% of the 80?





them in the past.

protection device?

MR. WATSON: I haven't got the details.

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Continued. 511. 101: Part is an

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MR. WATSON: For special nursing plans.

management will be equal to 80% of covered nursing expenses covered nursing expenses and all charges for services of registered graduate nurses, but only 75% thereof for services outside of a hospital.

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benefit is dependent upon the age and it ranges from 100 at the younger adult ages to 75 at the ages over 60. That is a monthly premium per individual. That is for special

plan, for the group it ranges from

50 at the younger adult ages to 35.25 at ages 60 and over. To have both these benefits combined, and these must be in addition to the basic plan, the premium would be monthly 60% at the young adult ages, ranging to 35.25 at the higher ages, 60 and over.

in these there is 60% of the charges.

There are certain conditions here which I am not mentioning, but it is 80% for the nurse and 75% for the charges. The CHAIRMAN: Do you mean 75% of the





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TORONTO, ONTARIO

Watson 10292

MR. WATSON: It comes to 60%. This is merely a basis for working out a premium and is illustrative in the sense that all our plans put forward are illustrative.



WATSON 11-22-61

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COMMISSIONER FIRESTONE: Well, sir, I am trying to relate these figures to what you gave us earlier on the average health cost per family. That is what the public is interested in knowing, the cost of the average, realizing it may be less when you are younger and more when you are older. What would you have to add to the \$10.50 and the \$12.50 you have given us earlier in terms of nursing and drug costs?

MR. WATSON: Roughly a dollar-and-a-half with the same medium-age group we were talking about before, roughly a dollar-and-a-half.

MR. FITZHUGH: For the family it would be \$3, about \$3.

MR. WATSON: I am sorry, yes, we had two children in there.

COMMISSIONER FIRESTONE: Two adults and two children.

MR. FITZHUGH: \$14 to \$16.50 the total would be.

MR. WATSON: \$3.30.

MR. FITZHUGH: \$3.30, take your choice.

COMMISSIONER FIRESTONE: Roughly about \$13 for the family with two children and \$16 for the family with three children?

MR. FITZHUGH: \$16.50.

COMMISSIONER FIRESTONE: \$16.50. I notice that you don't refer in this paragraph to the prepayment of dental services. Is there a special reason?

MR. WATSON: Generally speaking, dental



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Watson

COMMISSIONER FITZBONE: Well, sir,

I am trying to relate those figures to what you gave us earlier on the average health cost per family. That is what the public is interested in knowing, the cost of the average, realizing it may be less when you are younger and more when you are older. What would you have to add to the \$10.50 and the \$12.50 you have given us earlier in terms of nursing and drug costs?

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MR. WATSON: \$3.30.

MR. FITZBONE: \$3.30, take your choice.

COMMISSIONER FITZBONE: Roughly about \$18 for the family with two children and \$16 for the family with three children?

MR. FITZBONE: \$16.50.

COMMISSIONER FITZBONE: \$16.50. I

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Watson

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3 services are not being insured. I think one or two  
4 companies are insuring that benefit at the time, and  
5 it is in an experimental stage. Later this year,  
6 probably, there will be more companies in the field,  
7 so we couldn't put out any definite figure.

8 COMMISSIONER FIRESTONE: We appreciate  
9 that not many companies are in that field. The demand  
10 seems to be for a fairly comprehensive medical care  
11 program. I assume, under the term "comprehensive medical  
12 care", dental care is included. If there is a desire  
13 for prepayment plans would you feel this illustrative  
14 plan of yours could be extended to cover dental care as  
15 well?

16 MR. REID: May I ask a question of Dr.  
17 Strachan, Dr. Firestone? Has the dental profession, say,  
18 in Ontario, a schedule of fees in the same way that the  
19 doctors have under O.M.A.?

20 COMMISSIONER STRACHAN: Yes.

21 MR. REID: That is probably recent, is  
22 it not?

23 COMMISSIONER STRACHAN: For the past  
24 five, six years, I would say.

25 MR. FITZHUGH: Sir, we considered this  
26 dental question, and we know it is a very serious item  
27 of expense for Canadians. Our considered judgment is,  
28 at least, at the outset, as I said, used the phrase,  
29 we should walk before we run, and that plans should be  
30 confined to physicians, to doctors' costs and possibly  
31 drugs and nurses, if they go that far as optional addi-  
32 tional benefits.



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Wolcott

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program. I assume, under the term "comprehensive medical

care", dental care is included. If there is a desire

for prepayment plans would you feel this illustrative

plan of yours could be extended to cover dental care as

well?

MR. RYAN: May I ask a question of Mr.

Stratton, Dr. Finestone? Has the dental profession, say,

in Ontario, a schedule of fees in the same way that the

COMMISSIONER STRATTON: Yes.

MR. RYAN: That is probably correct, is

it not?

COMMISSIONER STRATTON: Yes, that is

five, six years, I would say.

MR. RYAN: Yes, we considered this

dental question, and we know it as a very serious item

of expense for Canadians. Our considered judgment is,

at least, at the outset, as I said, that the plan

we should wish before we run, and that plan should be

confined to physicians, to doctors, costs and possibly

nurses and nurses, if they go that far as optional

benefits.



Fitzhugh:

10295

The reason for that is the same as the reason that insurance companies are not assuring coverage now to any large extent. It is a very difficult area in which to guarantee prepayment of dental bills. I am speaking in the presence of a dentist, I know, but there is much elective work in connection with dentistry, the straightening of teeth, false teeth, and sometimes, obviously, it is a medical necessity, but sometimes it is for beautification purposes.

The plan envisages that any dental surgery as a result of accident or anything like that is covered, but the normal cleansing of teeth, repairing of cavities, extracting teeth, dentures and so forth, the variance between people as to the amount of necessary work in their mouths to get them into a normal state to start with; as I say, I am speaking in the presence of a dentist, but we haven't found any way of getting this within the comprehensive and insurable risk.

As Mr. Reid said experiments are being done. We may learn to do it. I hope we will learn this. At the moment we don't think we know how. We would urge that be omitted for the moment on the theory that we can't do everything we would like to do. That is the basic theory of economics, and again, I am out of my field, economics is the selection of how to do most of the things, the desirable things, within the resources available.

If we can't do everything we would like to do, this is one area we think that the economics of the matter would be in the way of having this coverage





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Fitzhugh

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3 for dentistry until we have a little more experience  
4 and experimentation.

5 MR. REID: More widespread fluoridation.

6 COMMISSIONER STRACHAN: Mr. Chairman,  
7 with your permission could I clarify Mr. Reid's question?  
8 I am not sure whether you asked Ontario or Canadian  
9 Dental Association.

10 THE CHAIRMAN: Ontario.

11 COMMISSIONER STRACHAN: Then my answer  
12 was correct.

13 MR. WATSON: Wouldn't it be fair to  
14 say, Mr. Fitzhugh, that experiments are going on in  
15 this field by certain companies?

16 MR. FITZHUGH: I think that was said.  
17 They are going on. We would like to see the results of  
18 them before we jump into a nationwide plan. That is  
19 our suggestion and advice.

20 MR. DREWRY: Some companies have plans.

21 MR. FITZHUGH: We have one, but we  
22 don't know enough to offer it to 18 million people.

23 COMMISSIONER STRACHAN: Might we have  
24 copies of these policies?

25 THE CHAIRMAN: Yes.

26 MR. FITZHUGH: I am sorry, Dr. Strachan?

27 COMMISSIONER STRACHAN: I asked if we  
28 might have copies of these policies and the Chairman  
29 said yes we could get them.

30 THE CHAIRMAN: We can get them through  
the Secretary.

COMMISSIONER FIRESTONE: You have been



for analysis until we have a little more experience  
and experimentation.

MR. WATSON: Now, what is the situation?

COMMISSIONER STRAUSS: Mr. Chairman,

with your permission could I clarify Mr. Rabin's question?

I am not sure whether you asked Ontario or Canadian

General Association.

THE CHAIRMAN: Yes.

COMMISSIONER STRAUSS: Yes, Mr. Watson.

MR. WATSON: Wouldn't it be better to

say, Mr. Fitzhugh, that experiments are going on in

this field by certain companies?

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THE CHAIRMAN: Yes.

MR. FITZHUGH: I am sorry, Mr. Chairman.

COMMISSIONER STRAUSS: I understand.

There are copies of these policies and the business

and you would get them.

THE CHAIRMAN: We can get them from

the Secretary.

MR. WATSON: Yes, Mr. Chairman.



Fitzhugh

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3 pointing out some of the difficulties in developing a  
4 plan of prepayment for dental care is the variety of  
5 services that a dentist offers his patient. I am just  
6 wondering whether the same principles which you have  
7 applied to developing a medical care plan as submitted  
8 to us, and that is standard care, basic minimum care,  
9 could not be applied to a dental plan in consultation  
10 with the dental profession, of course.

11 THE CHAIRMAN: I think that is what  
12 Mr. Fitzhugh said, after they have sufficient experience  
13 they would, yes.

14 MR. FITZHUGH: Yes.

15 THE CHAIRMAN: I think we have covered  
16 that. I think that is what we have already covered.

17 COMMISSIONER FIRESTONE: I am glad to  
18 hear you say there is a possibility of developing such  
19 a plan.

20 May I turn to Section F, Mr. Reid and  
21 gentlemen, in which you deal with the relationship of  
22 welfare expenditures in Canada and the gross national  
23 product? It is page 30. You say in paragraph 59, sir,  
24 and I quote:

25 "We believe that the emphasis in all  
26 welfare plans should be directed  
27 towards helping those who need assis-  
28 tance and who cannot, through their  
29 own efforts, achieve what is consi-  
30 dered to be the minimum standard of  
living."

Have you a definition in mind of "minimum



pointing out some of the difficulties in developing a  
plan of payment for dental care in the variety of  
services that a dentist offers his patient. I am just  
wondering whether the same principles which you have  
applied to developing a medical care plan as applied  
to us, and that is standard care, basic minimum care,  
could not be applied to a dental plan in consultation  
with the dental profession, of course.

THE CHAIRMAN: I think that is all.  
Mr. Fitzhugh said, after they have sufficient experience  
they would, yes.

MR. FITZHUGH: Yes.  
THE CHAIRMAN: I think we have covered  
that. I think that is what we have already covered.

COMMISSIONER FIFTHSTONE: I am glad to  
hear you say there is a possibility of developing such  
a plan.

May I turn to Section F, Mr. Fife and  
gentlemen, in which you deal with the relationship of  
welfare expenditures in Canada and the gross national  
product? It is page 30. You say in paragraph 29, 30, 31,  
and I quote:

"We believe that the emphasis in all  
welfare plans should be directed  
towards helping those who need assis-  
tance and who cannot, through their  
own efforts, achieve what is consi-  
dered to be the minimum standard of

have you a definition in mind of what is





Reid

10298

standard of living."?

MR. REID: Dr. Firestone, I don't think we are attempting to set up what is specifically and should be considered a minimum standard of living. It is our feeling it is not up to the Association to say what a minimum standard or where governments might feel they should properly come in with assistance. I don't think that is our duty. We haven't felt it is our duty to say where any such dividing line would be. It is for the governments, in their wisdom, in consultation, perhaps, with various welfare organizations, to say what is the minimum wage, living wage, for various types of families of various ages and under which some assistance might be given. We don't feel we are qualified to set that dividing line.

COMMISSIONER FIRESTONE: Well, I can see your point of view, Mr. Reid. Here we are talking about the introduction of a prepaid insurance plan made available on a premium basis that you would expect the majority of Canadians could afford, otherwise the plan wouldn't come into being. You also say if they cannot afford to pay this premium some government help would be appropriate.

If you have any views on this subject, you may not have them at the moment, but you realize in making a recommendation to the Government, assuming this recommendation was passed on to government of making financial contributions to pay the premiums of the indigent and medically indigent, some delineation of who they are would be required.

standard of living."

MR. KILB: Dr. Firststone, I don't

think we are attempting to set a standard of living, and should be considered a minimum standard of living. It is our feeling it is not up to the Association to say what a minimum standard of living governments ought to feel they should properly come in with assistance. I don't think that is our duty. We haven't felt it is our duty to say where any such dividing line would be. It is for the governments, in their wisdom, in consultation, perhaps, with various welfare organizations, to say what is the minimum wage, living wages, for various types of families of various ages and under which some assistance might be given. We don't feel we are qualified to set that dividing line.

COMMISSIONER FIRSTSTONE: Well, I can

set your point of view, Mr. Kilb. Here we are talking about the introduction of a prepaid insurance plan which is available on a premium basis that you would expect the majority of Canadians could afford, otherwise the plan wouldn't come into being. You also say it they cannot afford to pay this premium some government help would be appropriate.

If you have any view on this subject you may not have them at the moment, but you realize in making a recommendation to the government, especially this recommendation was passed on to government of making financial contributions to pay the premiums on the part and actually making some contribution of the they are would be required.



Watson

10299

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2  
3 I, personally, as a Commissioner, would  
4 feel in offering some advice I ought to say something  
5 about that. I don't know about my colleagues. We  
6 haven't discussed it. In developing such a plan we  
7 would feel that the insurance industry would have a  
8 lot to do with the public, that it is interested in  
9 working out various insurance schemes and we might be  
10 able to get some advice from you.

11 I appreciate there are economic considera-  
12 tions but also social and other considerations involved.  
13 This matter deserves careful review and thought. Would  
14 it be too much to ask you, Mr. Fitzhugh, if you and  
15 your colleagues would give some thought to this? If  
16 you have no views we will accept that in the best of  
17 spirit. If you could develop some views and you could  
18 offer some guidance it might be of great help to the  
19 Commission to have this guidance.

20 MR. WATSON: Dr. Firestone, may I make  
21 one comment in that connection which might be important  
22 to keep in mind? That is, most of our insurance that  
23 we sell is through group mechanism and the group mecha-  
24 nism depends on an employer contribution, so that even  
25 the employees who are at a minimal wage generally join  
26 this by virtue of the contribution the employer makes.

27 This is a very important fact to keep  
28 in mind when we discuss the plan, the amount of premium  
29 that would be required to provide certain plans. If it  
30 is done through group mechanism, we wouldn't normally  
write the plan unless the employer made a substantial  
contribution.





1. Section 2, as a whole, is...

...in order to give some advice I ought to say something about that. I don't know about my colleagues. We haven't discussed it. In developing such a plan we would feel that the insurance industry would have a lot to do with the public, that it is interested in working out various insurance schemes and we might be able to get some advice from you.

I appreciate there are some who are... I also social and other considerations involved. This matter deserves careful review and thought. Would it be too much to ask you, Mr. Fitzgibbon, if you and your colleagues would give some thought to this? If you have no views we will accept that in the first of all. If you could develop some views and you could offer some guidance it might be of great help to the Commission to have this guidance.

MR. WATSON: Mr. Fitzgibbon, may I make...

...some comment in that connection which might be important to keep in mind. That is, most of our insurance business is through group mechanism and the group mechanism depends on an employer contribution. In that case the employers are at a minimal wage generally. This by virtue of the contribution the employer makes. This is a very important fact to bear...

...in mind when we discuss the plan, the amount of premium that would be required to provide certain plans. It is in some through group mechanism, we wouldn't necessarily advise the plan unless the employer were a substantial contribution.





Reid

10300

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3 COMMISSIONER FIRESTONE: That is a  
4 most constructive comment. I hope we can get your  
5 views, that you would elaborate. It is not a simple  
6 thing of taking a figure out of the air. There are  
7 many considerations. This would be one of the considera-  
8 tions that one would bear in mind. In other words, I  
9 am asking you whether you feel you can make a contribu-  
10 tion to our thinking, otherwise we just have to rely on  
11 those people that are making submissions on this point  
12 and we get only one point of view. We would welcome it  
13 if we could have a contribution from you on the subject.

14 MR. REID: Dr. Firestone, I think our  
15 primary concern is to offer a plan which is feasible  
16 if the premiums are paid at a certain level. Whether  
17 people can afford to pay those premiums by themselves  
18 or whether governments want to assist, we hardly, as an  
19 Association, feel that this is something we should be  
20 determining.

21 Whether the government wants to contri-  
22 bute \$50 million or \$100 million or \$200 million to a  
23 plan to assist those in the lower income groups, we  
24 rather feel that that is for the government to decide  
25 and not for us to dictate or even suggest where the  
26 dividing line should be drawn. It is for government  
27 to determine how much they are prepared to put in for  
28 assistance to the low income groups, and for them to  
29 determine where that subsidy should start and stop.

30 I think it would be beyond our scope  
to suggest to government where they should determine  
this dividing line. We are merely offering what we feel



CONFIDENTIAL (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

What constructive criticism, I hope we can get a bit  
view, what you would like to see. It is not a simple  
thing of taking a thing out of the air. It is an  
very complicated thing. This would be one of the things  
which that one would need to find. In other words, I  
am sure, you certainly will not take a constructive  
thing to our table, otherwise we had have to rely on  
those people that are making suggestions on this point  
and we get into one point of view. We would welcome it.  
If we could have a consultation from you on the subject,  
I think our

primary concern is to offer a plan which is realistic  
of the present situation, at a certain level. We know  
people can do a lot of things, but we cannot do everything  
at the same time. We have to be realistic, as an  
Association, feel that this is something we should be

and the government wants to control  
about 100 million or 150 million dollars worth of a  
plan to assist them. In the seven income groups, we  
rather than that is for the government to decide  
and not for us to dictate or even suggest where we  
should be. It is the government  
to determine how they are going to put in the  
assistance to the low income groups, and for them to  
determine where that assistance should be placed and when.  
I think we would be better off if we

to assist to government where they are in trouble.  
This is a very important thing. We are sure of that.



Reid 10301

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3 is a feasible facility for covering all these people  
4 at a specific premium regardless of where the premium  
5 comes from.

6 THE CHAIRMAN: You are offering advice  
7 in the field in which you feel you are competent to  
8 offer it?

9 MR. REID: Exactly.

10 MR. WATSON: Could I add one little  
11 further point to that? This matter has already been  
12 decided in regard to the people at advanced age, 65 to  
13 69, in the field of old-age pensions. This type of  
14 determination has already been made by Provincial  
Governments.

15 COMMISSIONER FIRESTONE: In paragraph 60,  
16 Mr. Reid, you say, excessively large welfare expenditures,  
17 and then without going into all the details of the para-  
18 graph, you go on to say, bear more heavily on the enter-  
19 prising individuals in the community. You explain this  
20 is because of increased taxation.  
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E/I/ss

10302

COMMISSIONER FIRESTONE: I am just wondering whether the excessively large welfare expenditures are defined in accordance with the figures which you have presented in table shown in the Appendix V, on Page 7, where you have described, again as a projection of the gross national product, a gross of health expenditures and medical plan expenditures from \$792,000,000.00 in 1960 to \$2,375,000,000.00 in 1970 for health alone, plus \$610,000,000.00 for a medical care plan. In this Appendix, the conclusion which you offer to this Commission is that if health expenditure growing at the rate which you have indicated, the proportion of health and medical care expenditures of gross national product would rise from 2.2% to 5.8% in 1970. I am reading from the table on Page 7 of Appendix V. Now, sir, the question that I am putting to you is to refer these figures, as shown in your table, to your Paragraph 60. Would you, sir, consider an increase of health and medical care expenditures as per table on Page 7 in Appendix V, excessively large welfare expenditures in the meaning of Paragraph 60?

MR. REID: Well, Dr. Firestone, I think that about all we can comment today on that is that most of us are pretty alarmed now at the overall level of Government expenditures, and the size of the deficits that are evident, particularly at the Federal level already, and to a degree at the Provincial level, and while these of course, are merely estimates, the experience has been I think in nearly all countries that have introduced welfare plans, that expenditures are inclined to outrun the original estimates.





Reid 10303

These are figures that were prepared by our consulting economists. We had the same people make a survey in 1957 as to the likely rate of increase in welfare expenditures, and those figures were rather ridiculed in some quarters at the time, and yet the rising cost of hospital insurance in Ontario alone is already substantially outrunning the projections which were made in 1957, and, yes I think it is fair to say that we feel that if a percentage of 5.8% is devoted to this one field alone of health and medical care expenditures, along with all Government expenditures already committed, it is getting into a large figure, of which the health and medical care would be a substantial proportion.

COMMISSIONER FIRESTONE: You realize that this figure which is indicated under \$610,000,000.00 under expenditures for a medical plan includes large expenditures that are already being made by private individuals, either directly, or through various insurance arrangements, so therefore this does not represent a total net new cost to the Canadian nation. It includes large amounts that are already being paid for?

MR. REID: That is perfectly correct.

MR. DREWRY: But it assumes putting it through the tax system.

COMMISSIONER FIRESTONE: You are quite right. It would be paid in a different manner, but it would not be an additional amount of \$610,000,000.00?

MR. WATSON: It would mean new taxes for that amount.





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in welfare expenditures, and those figures were rather

reduced in some of the time, and yet the

rising cost of hospital care in Ontario alone is

already substantially exceeding the projections which

were made in 1957, and, as I said, it is fair to say

that we need that a percentage of 7.8% is devoted to

this one field alone of health and medical care expendi-

tures, along with all government expenditures already

committed, it is getting into a large figure, of which

the health and medical care would be a substantial pro-

COMMISSIONER FISHER: You realize

that this figure which is indicated under \$10,000,000.00

under expenditures for a medical plan includes large

expenditures that are already being made by private

individuals, either directly, or through various insurance

agreements, so therefore this does not represent a

total not now cost to the Canadian nation. Is that

large amount that are already being paid for?

MR. FISHER: That is perfectly correct.

MR. D. L. FISHER: But it assumes putting it

through the tax system.

COMMISSIONER FISHER: You are quite

right. It would be paid in a different manner, but it

would not be an additional amount of \$10,000,000.00

MR. WATSON: It would mean new taxes

on that amount.





Watson 10304

COMMISSIONER FIRESTONE: But people would not be paying the insurance premiums and other additional costs for medical service which is now being paid, so it does not mean the total amount will be increased to the extent of \$610,000,000.00. Is that correct?

MR. WATSON: I am just bringing out the fact that at the time the hospital insurance plan was put in in Ontario this same point was made, and we have today a sales tax in Ontario, and we have to think of any such process in the medical field as producing new taxes of the same kind.

COMMISSIONER FIRESTONE: Well, my last question, Mr. Reid, is, as you know, there is a growing demand in Canada for a comprehensive, prepaid health care plan, and my question, sir, is, that if the proposals that are contained in this plan, plus expanded facilities made by medically-sponsored, non-profit plans, plus an expanded Government plan for the indigent and medically indigent is provided, that the demand for a national health plan made by the Canadian people would in substance be met?

MR. REID: We feel that it would be largely met, given time. As you said, you don't accomplish anything overnight, and our plan, which we think would very substantially increase the coverage for a large group that at present cannot obtain it for one reason or another, or do not care to obtain it. If we obtain the necessary legislation, and that certainly would take considerable time, and we think it is an essential part of



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COMMISSIONER FINESTONE: But people

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the fact that at the time the hospital insurance plan was put in in Ontario this same point was made, and we have today a sales tax in Ontario, and we have to think of any such process in the medical field as producing new taxes of the same kind.

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Reid 10305

our plan to have this Provincial legislation, which would require participation in any losses in the pooling arrangement, we suggest that we could pretty satisfactorily cover a very large percentage of the population in due course.

Now, I think it is almost impossible to forecast exact figures and timing on it, but we have among our member companies a very large field organization, who I think would take this up quite enthusiastically. We hope they would, and that they would reach a great number of people who are not presently covered, but I wouldn't want to predict exactly how many, but I think it would greatly decrease any present demands for an overall scheme.

You referred earlier on to the adequacy of coverage, and as Mr. Watson has mentioned, the great bulk of us in the group field, and I can assure you that all our member companies are constantly endeavouring to extend existing coverage, but a large part of that is dependent on what the employer is prepared to contribute.

I do think it is rather significant that in the last two or three years, where we have lost practically all the hospital coverage we formerly had, and very large amounts, particularly in Quebec and Ontario, and in other provinces as well, that we have, insofar as premium income is concerned, largely offset that loss of hospital premiums by premiums for more comprehensive plans.

COMMISSIONER FIRESTONE: Well, Mr. Reid,





Page 10-105

our plan to have this Provincial legislation, which would require participation in any losses in the pooling arrangement, we suggest that we could pretty satisfactorily cover a very large percentage of the population in this country.

Now, I think it is almost impossible to forecast exact figures and timing on it, but we have among our member companies a very large field organization, who I think would take this as quite enthusiastically. We hope they would, and that they would reach a great number of people who are not presently covered, but I wouldn't want to predict exactly how many, but I think it would greatly decrease any present demands for an overall

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Fitzhugh 10306

and Mr. Fitzhugh and gentlemen, you have been very constructive in your answers, and very helpful. Thank you very much.

COMMISSIONER GIRARD: Mr. Fitzhugh, you spoke about a plan that would include nursing services in the hospital, and also outside of the hospital. By nursing services, I presume you mean special nurses?

MR. FITZHUGH: We didn't say, and should have said that this does not include the nurses employed by the hospitals.

COMMISSIONER GIRARD: It is special nurses?

MR. FITZHUGH: Yes.

COMMISSIONER GIRARD: Now, this plan outside of the hospital, if it was sold extensively, I wonder if we would have enough nurses to be able to give that service, if you made it on the proviso that it would be special nurses, that is a nurse going in the home for an eight-hour period, that you pay \$16.00 a day for, or whatever the rate is, according to the Province, but if this was on a visiting nurse basis, which might be better, the nursing service might have the facilities, because the nurse could go to two, three, or five or more patients in the same day. These are just thoughts I would like to leave with you, because I think if you start a plan that would give special nursing in the hospital and outside the hospital, I don't think the nursing profession would be able to cope with this, that is with the facilities we have just now.

MR. FITZHUGH: I think that is a very

and Mr. Fitzgibbon and Mr. Johnson, you have been very

you very much.

you make about a plan that would include nursing services

in the hospital, and also out of the hospital. By

providing services, I assume you mean nursing services?

Mr. Johnson: No, didn't say, and

should have said that this does not include the nursing

services in the hospital.

Mr. Johnson: It is a special

of course

Mr. Johnson: Yes,

Mr. Johnson: Now, your plan

outside of the hospital, is it was said extensively,

whether it would have enough nurses to be able to give

that service, if you made it on the provision that it would

be special nurses, that is a nurse going in the home for

an eight-hour period, that you say \$15.00 a day for, or

whether the rate is, depending on the province, but if

this was on a visiting nurse basis, which might be better

the nursing service might have the local area, and

the nurse would go to two, three, or five or more patients

in the same day. I am sure that brought in the line

to be a visiting nurse. I think it is a service, but

that you give special nursing in the hospital and the

side the hospital, I don't think the nursing service

should be able to cover that, that is what I think

and that is the point now.

Mr. Johnson: I think that is



Fitzhugh 10307

practical suggestion, Miss Girard. Again, we should walk before we run, and maybe we should include services of visiting nurses on some basis.

COMMISSIONER GIRARD: Everybody does not need a nurse eight hours by the bedside, and it is more economical both for the nurses and in terms of money to give care that is needed, without ----

MR. FITZHUGH: This would be like the services of the Victorian Order of Nurses?

COMMISSIONER GIRARD: Yes, or it could help in the development of existing services, which we feel should be extended to a further point than they are now, and this would help both ---

MR. DREWRY: In our recommendations we are recommending that there be encouragement of organizations providing home nursing and home-maker services.

MR. REID: I think one of the reasons that we are not too enthusiastic about jumping into this nursing field is that even those who can afford to pay for it find it hard to get a nurse today, and an insurance plan covering this would aggravate the situation.

COMMISSIONER GIRARD: We have the example now of hospitals being built, and once they are built coming to the Director of Nursing and saying now we need nurses to staff the hospitals, and we don't have the nurses, so I think it is better to go into it first.

MR. REID: I understand that there are two hospitals in Toronto here each with a whole wing that is not staffed.





...of suggestion, this is true. Again, we have said

...ing things on some cases.

...and we are also aware of the fact that it is

...the economic factor for the people and in terms of

...to give some idea of what is needed, without --

...this would be like the

...services of the Government of the United States

...on the part of the Government

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...we feel should be extended to a further point than they

...are now, and this would be a goal --

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...services.

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...that we are not too far from doing is to put this

...into effect, so that even those who are able to pay

...for it find it hard to get a home today, and an insurance

...plan covering that would be a great help.

...in the future, we have

...example now of people who are being helped, and we are

...trying to get to the point of the thing and we are

...we have hopes to still the hospitals, and we hope to

...the process, so I think it is better to go into it now

...in the future, I think

...there are two factors in the home care with a

...which is that it is not





Fitzhugh 10308

COMMISSIONER GIRARD: I don't say the plan should not go in. It is a good plan, but it needs further investigation to see if we have the facilities, and it might be a good thing if it can go in, because it would help to develop the home care facilities.

COMMISSIONER STRACHAN: I am sure my question is quite elementary, but having come through an experience in years gone by where one has bought one policy, and by persuasion of another insurance salesman he was convinced to change to another policy, I never know whether he did that rightly or wrongly, but here we have a standard policy referred to, and then such terms as the individual plan, a plan of your own choice can be obtained. It does not compel everyone to accept the same arrangement to provide for health care. In another place an individual decision is required. Are all of these statements consistent, and in view of the fact that you have said there would be no tricks or riders, with all the company variations which have been suggested, how is the average citizen to know what he has after the insurance salesman gets through with him?

THE CHAIRMAN: It is something like the car salesman, I suppose.

MR. FITZHUGH: There are basically two questions there as to the consistency between the individual choice and the one uniform plan. I guess we were not as clear as we might have been, that each company will continue to sell the diversity of plans that they are now selling, and their salesmen will say that they have the best policy, a policy better than another company's policy, and so forth, and there will be many different types of policies.





PM/hm

Fitzhugh

10309

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3 All our remarks about the individual choice were  
4 sincere ones. Where the uniformity come in is only for  
5 those who at the moment cannot buy a policy because  
6 they are uninsurable, no insurance company will issue  
7 them a policy and their choice will be restricted.

8 COMMISSIONER STRACHAN: At the maximum  
9 rate?

10 MR. FITZHUGH: Yes, the only policy  
11 they could get will be the basic policy ---

12 THE CHAIRMAN: Within the maximum?

13 MR. FITZHUGH: Their choice will be  
14 restricted but it is only a relatively small group who  
15 can now get nothing, those who come into the plan will  
16 have the whole gamut from which to select if they are  
17 willing to pay. The only thing they are guaranteed at  
18 a guaranteed rate is these two policies and if they want  
19 anything more they can pay for it.

20 As to how the individual decides what  
21 he wants to buy, I think we can go back again to the  
22 fundamental of free enterprise; if he is going to have  
23 the choice of buying different things he has got to be  
24 presumed to be able to make a choice and we think by and  
25 large the Canadian people have made intelligent choices  
26 as to which kind of plan they want. There was a time  
27 when it was alleged that insurance companies engaged  
28 in sharp practices and their salesmen did not tell the  
29 truth.

30 THE CHAIRMAN: We are not enquiring  
into the practise of the insurance companies.

MR. FITZHUGH: I understand that, but





All our members about the individual choice were  
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 they are uninsured, no insurance company will issue  
 them a policy and their choice will be restricted.  
 COMMISSIONER CORBETT: At the moment

There?

MR. FITZGERALD: Yes, the only policy  
 they could get will be the basic policy --  
 MR. CHAIRMAN: Within the next year  
 MR. FITZGERALD: Their choice will be  
 restricted but it is only a relatively small group who  
 can now get nothing; those who come into the plan will  
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 willing to pay. The only thing they are guaranteed at  
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 truth.

MR. CHAIRMAN: We are not examining  
 into the practices of the insurance companies.  
 MR. FITZGERALD: I understand that, but





Fitzhugh

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3 that is a question I am glad came up. How does the  
4 individual know? I think at the present time the  
5 individual is told that under the provincial regulatory  
6 authorities if any company does not want to make it  
7 clear what he is buying, the policies have to contain  
8 certain provisions, they have to be of a certain size  
9 and they cannot have trick questions and that kind of  
10 thing. I think any person ---

11 THE CHAIRMAN: You are not selling me  
12 a policy this morning, you do not have to make that  
13 pitch.

14 MR. FITZHUGH: I will shut up.

15 THE CHAIRMAN: Not that we are not  
16 pleased to have you here but we must remain within the  
17 ambit of our enquiry. At times of course we roam and  
18 the Commissioners roam and those who come before us  
19 roam but we are very grateful to you. This submission  
20 is a very constructive piece of work by an industry and  
21 it is going to be very helpful to us. The ideas which  
22 you have expressed here this morning are going to be  
23 very helpful and we are very grateful to you and the  
24 companies you represent.

25 We will have a short recess.

26 ---Short recess.

27 THE SECRETARY: Mr. Chairman, the  
28 next submission is the Canadian Cancer Society which  
29 will be known as exhibit 281.

30 ---EXHIBIT NO. 281: Submission of Canadian  
Cancer Society.



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individual is told that under the provision of the

authorities if any company does not want to take it

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certain provisions, they have to be of a certain size

and they cannot have trick questions and that kind of

thing. I think any person --

THE CHAIRMAN: You are not selling me

a policy this morning, you do not have to leave that

MR. TINKER: I will just say

THE CHAIRMAN: Now that we are now

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limits of our enquiry. At times of course we have and

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is a very constructive piece of work by an industry and

it is going to be very helpful to us. The ideas which

you have expressed here this morning are going to be

very helpful and we are very grateful to you and the

companies you represent.

We will have a short recess.

--- out recess.

THE SECRETARY: Mr. Chairman, the

next submission is the Canadian Cancer Society which

will be known as exhibit 381.



SUBMISSION OF  
CANADIAN CANCER SOCIETY

APPEARANCES: Mr. F. McEachren  
Dr. R.M. Taylor  
Mr. G. Pifher

MR. McEACHREN: Mr. Chairman and members of the Commission: I have two members of the Canadian Cancer Society with me today. On my right is Dr. Taylor, executive vice-president and on my left Mr. George Pifher, executive treasurer of the Society.

The Canadian Cancer Society has endeavoured to present in the attached brief a general review of the problems related to the various aspects of the cancer control programme in which it has participated. Several recommendations have been advanced which the Society believes should be considered in health plans. They are:-

1) Needs peculiar to the patient with cancer

(a) Payment of transportation costs:

It is recommended that the cost of transportation to and from treatment centres be considered a part of the cost of treatment, and that provision for the payment of such costs be included in health plans. It is estimated that the average annual cost of transportation is \$34.00 per patient and that approximately 15,000 patients would be eligible for such coverage.

(b) Provision of hostel accommodation for out-of-town ambulatory patients: The concentration





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SUBMISSION

Dr. W. N. Taylor

MR. McEACHERN: Mr. Chairman and

members of the Commission: I have two members of the Canadian Cancer Society with me today. On my right is Dr. Taylor, executive vice-president and on my left Mr. George Fisher, executive treasurer of the Society.

The Canadian Cancer Society has

endeavouring to present in the attached brief a general review of the problems related to the various aspects

of the cancer control programme in which it has

participated. Several recommendations have been advanced which the Society believes should be considered in health

plans. They are:-

1) Provision of the patient with cancer

(a) Payment of transportation costs:

It is recommended that the cost of transportation to and from treatment centres be considered a part of the cost

of treatment, and that provision for the payment of

such costs be included in health plans. It is estimated that the average annual cost of transportation is \$34.00

per patient and that approximately 10,000 patients would be eligible for such coverage.

(b) Provision of hospital accommodation





McEachren

10312

of radiation therapy centres and the nature of such treatment makes it necessary for ambulatory patients to find accommodation for the period of treatment. The value of hostels, or lodges, has been established and it is recommended that provision of the capital funds necessary for the construction of additional lodges, where circumstances warrant, be included in health plans.

Existing lodges are not accredited for inclusion in hospital plans at the present time; as it is recommended that this type of institution be so accredited.

2) Needs common to all patients with chronic diseases

(a) Home Care: The Society believes that hospital-based and other organized home care medical services are desirable in the management of chronic disease. Pilot home care projects which have been set up in Canada and the United States are demonstrating that the cost of this form of maximum care of home-bound patients is much less than the cost of their maintenance in hospitals. It has been estimated by one hospital that the cost of providing total home care, involving some 700 cancer patients over a 14-year period, has reached \$5.00 per day per patient.

(b) Payment of the cost of drugs:  
It is recommended that the payment of the cost of drugs used by out-patients in the treatment for cancer be included in health plans.



of radiation therapy centres and the nature of such treatment makes it necessary for ambulatory patients to find accommodation for the period of treatment. The use of hostels, or lodges, has been established and it is recommended that provision of the capital funds necessary for the construction of additional lodges, where circumstances warrant, be included in health

Building lodges are not recommended for inclusion in hospital plans at the present time; it is recommended that this type of institution be so recorded.

Needs common to all patients with chronic diseases

(a) Home care: The patient's behaviour in the hospital-based and other organised home care medical services are desirable in the management of chronic disease. First home care projects which have been set up in Canada and the United States are demonstrating that the cost of this form of maximum care of home-bound patients is much less than the cost of their maintenance in hospitals. It has been estimated by one hospital that the cost of providing home care, involving some 700 cancer patients over a 14-year period, has reached \$5.00 per day per patient.

(b) Payment of the cost of home care: It is recommended that the payment of the cost of home care by out-patients in the treatment for cancer be included in health plans.



3) GENERAL

It is the belief of the Society that voluntary efforts, backed by public support are essential to the efficient promotion and management of public health; and that this voluntary participation, supported by the good will and charity of Canadians, should continue to flourish under any health plans that may be devised.

THE CHAIRMAN: Thank you, Mr. McEachren. I would ask Dr. Baltzan if he will discuss this brief with you.

COMMISSIONER BALTZAN: I really have not too many questions because your statements are very clear. You are speaking about the transportation costs, this would apply to all people who have cancer to go to areas where they can have the proper treatment. That should be provided for everyone irrespective of whether they can pay or not pay?

MR. PIPHER: I think that is the proposal contained here that the means test should be abolished in regard to transportation for cancer patients. A means test is applied at the present time in two or three provinces, in one province a very liberal means test is applied on a family income basis of \$3,500.00 a year and all under that are entitled to receive payment or reimbursement on transportation costs. The intent here is that this would be without regard for the means of the family.

COMMISSIONER BALTZAN: In other words, as soon as one is declared to have this sort of condition



It is the belief of the industry that

voluntary efforts, backed by public support and  
essential to the efficient protection and maintenance of  
public health; and that this voluntary participation,  
supported by the good will and ability of Canadians,  
should contribute to the health and safety of the public  
may be devised.

THE CHAIRMAN: Thank you, Mr.

Chairman, I would ask Mr. Chairman if he will discuss  
this brief with you.

COMMISSIONER BARTON: I really have

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very clear. You are speaking about the transportation  
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no to areas where they can have the proper treatment.  
That should be provided for every one irrespective of  
whether they can pay or not pay?

MR. BARTON: I think that is the

proposal outlined here that the means test should be  
abolished in regard to transportation of cancer patients.  
A means test is applied at the present time in two or  
three provinces, in one province a very liberal means  
test is applied in a testing time period of 12 months  
a year and all under that are entitled to receive  
payment of transportation or transportation costs. The  
intent here is that this would be without regard to  
the means of the family.

COMMISSIONER BARTON: I have a few more

at 10:00 as far as the means test is concerned.





Pifher

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4 and requires this sort of treatment periodically,  
5 automatically it would apply in this province for all  
6 people?

7 MR. PIFHER: That is right.

8 COMMISSIONER BALTZAN: How about your  
9 treatments? They vary province to province, are they  
10 received on a so-called means test basis?

11 DR. TAYLOR: This varies from province  
12 to province. The only province I think at the moment  
13 that gives all treatment without cost to the patient  
14 is the Province of Saskatchewan. The other provinces  
15 vary and in most cases treatment is not denied because  
16 of ability to pay but the patient is expected to pay  
17 if he can contribute.  
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and reduction this sort of treatment undoubtedly  
automatically it would apply in this manner for all  
people?

MR. FLETCHER: That is right.  
DR. TAYLOR: I am sorry you  
treatments. They vary from one to another, and then  
there is on a combined basis with surgery.

DR. TAYLOR: This varies from person  
to person. The only person I think at the moment  
that gives all treatment without cost to the patient  
is the province of Saskatchewan. The other provinces  
vary and in most cases treatment is not likely because  
of lack of money the patient is expected to pay  
it as an individual.

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Taylor

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THE CHAIRMAN: But in-hospital must be covered, everything?

DR. TAYLOR: Yes. My comment really was treatment on an out-patient basis.

COMMISSIONER BALTZAN: Cancer patients entering in this area, your Canadian Society, are they taken in under this special hospitalization scheme or are they taken in under the cancer departments, for in-hospital treatment? Are they in cancer institutes?

DR. TAYLOR: By and large they are not, sir. With perhaps really only one exception I can think of, patients are admitted to the general hospitals.

COMMISSIONER BALTZAN: Where they have institutes for the care and treatment of patients, and there are such institutes, that is just related to research, are they covered by ---

THE CHAIRMAN: Are you dealing with Ontario?

COMMISSIONER BALTZAN: In most areas. I am taking the Canadian view, if you have a view on it.

DR. TAYLOR: In Toronto there is the Canadian Cancer Institute which is under the auspices of the Ontario Cancer Treatment and Research Foundation which is for the admission and treatment of patients. This is the only centre where patients are admitted for active treatment.

COMMISSIONER BALTZAN: Does your Society, outside of making a contribution, pay for the care of



1945 Taylor

The Committee on In-hospital Care

is covered, everything.

Dr. TAYLOR: Yes, by covering only

was treatment on an out-patient basis.

Dr. TAYLOR: I am a cancer patient

entering in this case, your Cancer Society, and now

taken in under this special hospitalization scheme on

are they taken in under the cancer treatments, for

in-hospital treatment? Are they in cancer hospitals?

Dr. TAYLOR: Yes and I am sure they are

not, sir. With perhaps really only one exception I

can think of, patients are admitted to the general

hospitals.

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Dr. CHALKER: Yes, in most cases.

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Dr. TAYLOR: In Toronto there is the

Canadian Cancer Institute which is under the auspices

of the Ontario Cancer Treatment and Research Foundation

which is for the education and treatment of patients.

This is one of the places where patients are admitted for

active treatment.

Dr. TAYLOR: Yes, your answer

outside of making a contribution, and for the care of





Taylor

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patients?

DR. TAYLOR: The Canadian Cancer Society does not contribute to the care of patients in the hospital; it tries to keep out of participation in the cost of treatment.

COMMISSIONER BALTZAN: And you find there will be advice on the part of voluntary efforts of interested people in this matter of the cancer problem and the ways and means of helping people get to places, looked after and meet any problems?

DR. TAYLOR: Yes, sir.

COMMISSIONER BALTZAN: In other words, while you hope that cancer will disappear, you don't want to go out of business?

DR. TAYLOR: We would be glad to go out of business.

COMMISSIONER GIRARD: Mr. Chairman, on page 2, paragraph 2(b):

"Payment of the cost of drugs: It is recommended that the payment of the cost of drugs used by out-patients in the treatment for cancer be included in health plans."

I am under the impression that in some hospitals, at least the drugs are given free to cancer patients in the out-patient department. Would this be general or would this be in certain provinces only, and is the cost of these drugs borne by some cancer organizations? I know it is being given, but I don't know who pays for it.



patients?

MR. TAYLOR: The question of a patient does not contribute to the same of course in a hospital; it tries to keep out of hospitalization, the cost of treatment.

MR. TAYLOR: I think that the fact that there will be advice on the part of voluntary efforts of interested people in this matter of the hospital and the ways and means of helping people to be cured, looked after and meet any expenses.

MR. TAYLOR: Yes, sir.

MR. TAYLOR: I think that the fact that you hope that our work will disappear, you don't want to go out of business.

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MR. TAYLOR: Yes, sir.



Pifher

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MR. PIFHER: It is not general. Where it does apply it usually applies to the therapeutic drugs. Pain-killing drugs are not usually paid for by out-patient facilities. Our Society has undertaken in a small way to fill this gap. Some 1,250 patients were provided with pain-killing drugs throughout Canada at a cost to us of something like \$42,000. But this doesn't cover the total need; we are really filling in a small way the gap that exists. But where the out-patient services are provided it is for therapeutic drugs.

In the patchwork quilt of the cancer story in Canada there are exceptions. In Alberta there are provisions for therapeutic drugs without a means test for cancer patients. Pain-killing drugs are not provided, and this is as far as we can go in our organization.

COMMISSIONER GIRARD: Thank you very much.

COMMISSIONER FIRESTONE: Mr. McEachren, do we know how much money is available to the Canadian Cancer Society under federal-provincial grants?

MR. McEACHREN: I will ask Mr. Pifher to answer that.

MR. PIFHER: Nothing, no money.

COMMISSIONER FIRESTONE: Is it your recommendation that funds be made available?

MR. PIFHER: No.

THE CHAIRMAN: I understand you are the collecting arm in the main for the National Cancer Institute.



Mr. PINKER: It is not general. There

it does apply it usually applies to the therapeutic drugs. Pain-killing drugs are not really paid for by out-patient facilities. Our Society has been taken in a small way to fill this gap. Some 1,500 patients were provided with pain-killing drugs throughout Canada at a cost to us of something like \$25,000. But this doesn't cover the total need; we are really filling in a small way the gap that exists. But where the out-patient services are provided it is for therapeutic drugs.

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COMMISSIONER GIBSON: Thank you very

much.

do we know how much money is available to the Canadian Cancer Society under federal-provincial grants?

Mr. Macdonald: I will ask Mr. Wilson

to answer that.

Mr. Wilson: Nothing, no money.

COMMISSIONER GIBSON: Is it worth

recommendation that funds be made available?

Mr. PINKER: No.

Mr. GIBSON: I understand you are

collecting arms in the main for the National Cancer

Association.





Pifher 10318

MR. PIFHER: That is not the major function. About 45% of the money we raise each year goes to the National Cancer Institute for the support of its research program. The balance of the money is spent on our own problems for cancer services and care of patients.

COMMISSIONER FIRESTONE: And you feel you are able to obtain adequate funds and there is no need for you to receive any government money for your organization?

MR. PIFHER: We believe we can handle this situation very satisfactorily.

COMMISSIONER McCUTCHEON: Are we not getting into rather a difficult field if you try to distinguish between a cancer patient and another patient, in transportation? Someone may come a very long distance for treatment.

MR. McEACHREN: Yes, I think we are, but we felt our job was to recommend for cancer patients, not for all patients. We are the Cancer Society, not a general health society.

COMMISSIONER McCUTCHEON: You are here grinding your own axe.

MR. McEACHREN: I think it is true to say that a cancer patient, because of the therapy centres being located in various places, may require some transportation.

COMMISSIONER McCUTCHEON: Mr. Pifher said that about 45% of the money went to the National Cancer Institute. What proportion would you say was



MR. FITZGERALD: That is not a job

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defining your own area.

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say that a cancer patient, because of the therapy, requires being located in various places, may require some trans-

COMMISSIONER McINTOSH: Mr. Fitz

said that about 45% of the money went to the National Cancer Institute. What proportion would you say was



McEachren

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devoted to welfare and what proportion to education?

MR. McEACHREN: Approximately a third and a third and a third. A third goes to research, a third to education, a third to welfare. In Saskatchewan there is no need for as much welfare as we have in particular provinces.

COMMISSIONER McCUTCHEON: What do you raise? What are you raising annually at the present time across Canada?

MR. PIFHER: About 3 million to 3.1/2 million. 3,600,000 this year and last year our total income from campaign was around 4 million dollars.

COMMISSIONER McCUTCHEON: Something about a million-and-a-half would be going directly into the welfare field?

MR. PIFHER: Our expenditures are on page 2 of the brief, and I think the percentages there of cancer education and welfare services over the 14-year period are approximately the same as the percentages for last year. They would vary very little.

COMMISSIONER McCUTCHEON: Some of these recommendations, if implemented, would reduce, shall we say, the burden on the welfare side of your budget and to that extent, assuming you can maintain your fund-raising at the present level, would provide more money for research or for other purposes?

MR. PIFHER: That is right.

COMMISSIONER McCUTCHEON: You haven't attempted to put a cost on this item?

MR. PIFHER: Well, we can give you an





devoted to welfare and what proportion to education.

MR. McBRIDE: Approximately a third

and a third and a third. A third goes to research,

third to education, a third to welfare. In other words,

there is no need for as much welfare as we have in

present provisions.

COMMISSIONER McBRIDE: What do you

mean? What are you raising annually at the present

time across Canada?

MR. McBRIDE: About 3 million to 3.5

million. 3,500,000 this year and last year was total

income from taxation was around 4 million dollars.

about a million-and-a-half would be going directly into

the welfare field.

MR. McBRIDE: Our expenditures are on

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say, the burden on the welfare side of your budget and

to that extent, assuming you can maintain your level

raising at the present level, would provide some money

for research or for cancer services?

MR. McBRIDE: That is a hard

question to answer. I am not sure

whether it is a question of

MR. McBRIDE: Well, we are going to



Pifher

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estimate, which is purely an estimate. Based on our experience in Nova Scotia, we would estimate something like under \$500,000 a year would be required for the transportation of all patients and then, with regard to the provision of hostel accommodation for out-of-town ambulatory patients ---

COMMISSIONER McCUTCHEON: You are not doing that now?

MR. PIFHER: No. All we are doing is to provide capital funds. With regard to the home care program, which is 2(a), the only estimate we have there is based on American experience. The Canadian projects haven't reached the stage where an adequate cost can be arrived at. Based on the experience in a hospital in the States at \$5 a day, we estimate the bill for taking care of patients in their home would be something over \$11 million a year.

COMMISSIONER BALTZAN: How do you find your campaign in the last few years?

MR. PIFHER: We are very fortunate we have enjoyed the co-operation of the public in that our objectives have been obtained each year.

COMMISSIONER BALTZAN: Increasing each year?

MR. PIFHER: Yes. Our support to the National Cancer Institute has increased 25% each year.

COMMISSIONER McCUTCHEON: Can you put any price on the cost of drugs?

MR. PIFHER: No. Our knowledge of the cost of drugs - we provide at a cost of \$42,000-odd,



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estimate, which is purely an estimate, based on our  
experience in Nova Scotia, we would estimate something  
like under \$200,000 a year would be required for the  
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MR. FIFTH: No. All we are doing is to

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MR. FIFTH: No. Our knowledge of the

cost of drugs - we provide at a cost of \$42,000-45,





Pifher

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which would work out to something like \$45 per patient. Now, that would be pain-killing drugs only, and we have no cost with regard to therapeutic drugs. In some provinces we do not provide drugs of any kind.

COMMISSIONER McCUTCHEON: There are other agencies which do provide drugs in certain provinces, I understand?

MR. PIFHER: In some provinces there is no known agency providing them at all.

COMMISSIONER McCUTCHEON: But in other provinces there are such agencies besides the Canadian Cancer Society?

MR. PIFHER: Yes, therapeutic drugs.

COMMISSIONER McCUTCHEON: Thank you very much.

THE CHAIRMAN: Mr. McEachern, Mr. Pifher, what would be the mechanism for paying for the transportation?

MR. PIFHER: Well, there again, the only example we have of an adequate mechanism having been established is in Nova Scotia where we handle the whole transportation arrangement for the province and they are reimbursed quarterly. We administer the whole thing for them.

THE CHAIRMAN: Take a patient who has to go from his home to where he is going to be treated. How do you come into the picture?

MR. PIFHER: This is done by the official treatment agency in the clinic.

THE CHAIRMAN: Is it in advance or on a





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COMMISSIONER MCCUTCHEN: Thank you

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How do you come into the picture?

MR. PIERCE: This is done by the

official treatment agency in the clinic.

THE CHAIRMAN: Is it in advance or on a



Pifher

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reimbursement basis?

MR. PIFHER: We are reimbursed. The arrangements must be made in advance because they could not come in without prior arrangements. We provide the funds in advance if it is required.

COMMISSIONER STRACHAN: Does this include intra-city transportation?

MR. PIFHER: You mean internal?

COMMISSIONER STRACHAN: Yes.

MR. PIFHER: No, it is done by voluntary drivers within the area at no cost.

COMMISSIONER BALTZAN: When a patient receives an appointment and is told to return in three months, say, does the patient then notify the clinic "I have to come back. My expenses are so much and I haven't got the funds."?

MR. PIFHER: In Nova Scotia the transportation is paid for all follow-up visits, whether they come 10 times or 20 times.

COMMISSIONER BALTZAN: Or with their own cars?

MR. PIFHER: This is really reimbursing if they have no other form of transport. If a friend drives them in the friend wouldn't be paid. This is where they have to pay for transportation.

COMMISSIONER BALTZAN: You don't provide mileage if they drive their own car?

MR. PIFHER: No.

THE CHAIRMAN: Is this per income?

MR. PIFHER: Yes, per family income.



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Appointments must be made in advance because they would not come in without prior appointments. We provide the funds in advance if it is required.  
COMMISSIONER STRACHAN: Does this

MR. PIERCE: You mean internal?

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THE CHAIRMAN: Is this per income?

MR. PIERCE: Yes, per family income.



THE CHAIRMAN: Thank you, Mr. McEachern,  
Dr. Taylor, Mr. Pifher.

We are going to hear more regarding  
cancer this afternoon when we have the National Cancer  
Institute and the Ontario Cancer Treatment and Research  
Foundation, so the composite submissions which you have  
given make a very clear picture and we are very grateful  
to have your assistance here this morning.

We will rise and continue at 2 o'clock.

--- Luncheon adjournment.





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THE CHAIRMAN: Thank you, Mr. McGowan.

Mr. Taylor, Mr. Fisher.

We are going to hear some reports.

During this afternoon when we have the National Cancer Institute and the Genetic Cancer Treatment and Research Foundation, so the composite submission which you have given make a very clear picture and we are very grateful to have your assistance here this morning.

We will rise and continue at 2 o'clock.

--- Lunchroom adjournment.



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---Upon resuming.

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DR. JOBIN: The next submission will be that of the National Cancer Institute of Canada. This exhibit will be known as number 282. The presentation of the brief will be made by Dr. Warwick. Will you please introduce your colleagues, Dr. Warwick.

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SUBMISSION OF  
NATIONAL CANCER INSTITUTE OF CANADA

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EXHIBIT NO. 282: Submission of the National Cancer Institute of Canada.

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APPEARANCES: Dr. R.M. Taylor  
Dr. O.H. Warwick  
Mr. Pifher

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DR. WARWICK: I am vice-president of the National Cancer Institute. You have met Dr. Taylor the executive director and Mr. Pifher who is honorary treasurer.

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The National Cancer Institute of Canada was established in 1947; its main efforts have been to support and co-ordinate research on the clinical and basic aspects of cancer, to promote professional education about cancer, to compile and interpret cancer statistics and to assist in the co-ordination of provincial cancer control programmes.

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In pursuance of these objects the Institute's annual expenditure has grown from \$143,000 in 1947-48 to an estimate \$1,700,000. in 1962-63.



---Upon receiving.

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as that of the National Cancer Institute of Canada.  
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SUBMISSION OF  
NATIONAL CANCER INSTITUTE OF CANADA

Submission of the National  
Cancer Institute of Canada.

EXHIBIT NO. 282:

Dr. R. M. Taylor  
Dr. O. H. Warwick  
Mr. P. H. P. H.

WITNESSES:

Dr. WARWICK: I am vice-president of  
the National Cancer Institute. You have met Dr. Taylor  
the executive director and Mr. P. H. P. H. who is honorary

1. The National Cancer Institute of  
Canada was established in 1947; its main efforts have  
been to support and co-ordinate research on the clinical  
and basic aspects of cancer, to promote professional  
education about cancer, to compile and interpret cancer  
statistics and to assist in the co-ordination of  
provincial cancer control programmes.

2. In pursuance of these objects the  
Institute's annual expenditure has grown from \$100,000  
in 1947-48 to an estimate \$1,700,000. in 1962-63.





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4 At this point, Mr. Chairman, I would  
5 like to augment my remarks by saying in the overall  
6 support of cancer research in Canada that it is really  
7 only in this province through the Ontario Cancer  
8 Foundation that any other support is given for cancer  
9 research and as Dr. Cosbie and Mr. Broughton will say  
10 in the presentation of the next brief that their  
11 contribution is considerable in support of cancer research  
12 but the National Cancer Institute carries the remainder  
13 of the provinces.

14 4. ~~From 1947 to 1948~~ An increasing proportion of the  
15 Institute's research budget is devoted to long term  
16 commitments to support Research Units and Research  
17 Scientists; by 1964 this proportion will be almost 60%.  
18 5. ~~Since 1947-48~~ Since 1947-48 the Federal Government  
19 has increased its support of extramural medical  
20 research from \$547,000 to \$8,200,000, an increase of  
21 1500%. During that time the support of the National  
22 Cancer Institute from Federal, as well as from Provincial,  
23 sources has grown from \$121,000 to a maximum of  
24 \$271,000.

25 6. ~~To ensure that long term support~~ To ensure that long term support  
26 will continue to be available for research it is  
27 recommended that, inasmuch as the Institute is the  
28 instrument of the Federal Government for the support of  
29 of research on cancer, the Government increase its support  
30 the Institute's research programme in parallel with the  
increases which have been provided for other areas of  
medical research in Canada, and that its support be  
provided in the form of direct grants to the Institute.  
I might amplify this.



at this point, Mr. Chairman, I would like to augment my remarks by saying in the overall support of cancer research in Canada that it is really only in this province through the Ontario Cancer Foundation that any other support is given for cancer research and as Dr. Gossie and Mr. Brophy will say in the presentation of the next brief that their contribution is considerable in support of cancer research at the National Cancer Institute carries the remainder of the provinces.

4. An increasing proportion of the Institute's research budget is devoted to long term commitments to support Research Units and Research Scientists; by 1984 this proportion will be about 80%. Since 1947-48 the Federal Government

has increased its support of experimental medical research from \$57,000 to \$8,200,000, an increase of 150%. During that time the support of the National

sources has grown from \$121,000 to a maximum of

6. To ensure that long term support will continue to be available for research it is

recommended that, inasmuch as the Institute is the instrument of the Federal Government for the support of research on cancer, the Government increase its support of the Institute's research programme in parallel with the

increase which have been provided for other areas of medical research in Canada, and that its support be

provided in the form of direct grants to the Institute. I must amplify this.



Warwick

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4 THE CHAIRMAN: If you will.

5 DR. WARWICK: There is no intention  
6 in this submission that in asking for additional funds  
7 that there should be any decrease in the amount of  
8 monies made available to the Province for their overall  
9 cancer programs.

10 7. The role of the voluntary agency in  
11 the field of cancer research will be as important in the  
12 future as it has been in the past.

13 THE CHAIRMAN: Would you care to  
14 expand on that, supposing there is a break-through?

15 DR. WARWICK: Well, sir I think there  
16 might be two types of break-through in the cancer field.  
17 It is possible some means might be found whereby the  
18 disease might be prevented, in which case education and  
19 welfare would become of increasing importance. Now  
20 effective methods of treatment might become available,  
21 even if this were the case, I think education and  
22 welfare would still be important, so the Cancer Society  
23 would still have education and welfare to be concerned  
24 with. What we mean to say, so long as cancer research  
25 is necessary those of us interested in the field would  
26 like to feel that voluntary support could continue in  
27 addition to government support.

28 THE CHAIRMAN: Just what do you mean,  
29 I don't mean this to be critical, what do you mean  
30 government increase support of the Institute's research  
program in parallel with the increases which have been  
provided for other areas in medical research in Canada.  
In the preceding paragraph you acknowledge an increase  
of 1500%.





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THE CHAIRMAN: If you will.

DR. WATSON: There is no question

in this submission that in asking for additional funds that there should be any decrease in the amount of monies made available to the Province for their overall

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provided for other areas in medical research in Canada.

In the preceding paragraph you acknowledged an increase

of 1961.



Warwick

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4 DR. WARWICK: That has been the  
5 increase for federal support to medical research over  
6 this period, other than the cancer research, 1500%.  
7 The increase to support cancer has been only from \$121,000  
8 to \$271,000.

9 THE CHAIRMAN: I am sorry.

10 DR. WARWICK: Which is less than 100%

11 THE CHAIRMAN: You want to have the  
12 same proportion?

13 DR. WARWICK: It is our feeling we  
14 would like to see increasing form of government support.  
15 We feel that the voluntary agency is carrying increasingly  
16 heavy commitments and these commitments are of a  
17 serious nature in that there are long term commitments  
18 to the research work in the field across the country.

19 THE CHAIRMAN: In using the words  
20 medical research are you excluding -- no part of that  
21 \$8,200,000 was allocated to cancer research?

22 DR. WARWICK: None of that.

23 THE CHAIRMAN: None of that to the  
24 Institute?

25 DR. WARWICK: No, I think we can go  
26 further than that, sir, and say that in each year  
27 since the founding of the National Cancer Society,  
28 since the war, applications were made by people wishing  
29 to do cancer research to the various fund granting  
30 bodies. The representative said to go, to sort out  
to which group that might logically be directed, and  
any of the work related to cancer research would come  
to the National Cancer Institute. In addition to this



Warwick

DR. WARWICK: That has been the

increase for Federal support to national research over

this period, other than the cancer research, 1968.

The increase to support cancer has been only from \$11,000

to \$12,000.

THE CHAIRMAN: I am sorry.

DR. WARWICK: Which is less than 1968.

THE CHAIRMAN: You want to have the

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to the research work in the field across the country.

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DR. WARWICK: None of that.

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further than that, sir, and say that in each year

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3 amount, as I amplified before, the Ontario Cancer  
4 Foundation in this area was in the cancer research  
5 field some four years before the National Cancer  
6 Institute was formed and it has continued to carry on  
7 very active cancer research programs.

8 THE CHAIRMAN: Just to continue in  
9 my uninformed view, you know there has recently been  
10 constructed on the campus at Saskatoon a cancer  
11 research institute. Who operates that? What is the  
12 origin and so forth of that?

13 DR. WARWICK: My understanding, and  
14 Dr. Taylor can correct me, is that funds for the  
15 construction of that unit were made available by the  
16 Saskatoon division of the Canadian Cancer Society. The  
17 funds for the maintenance of research in the institution  
18 are supplied by the National Cancer Institute of Canada,  
19 85% of which comes from the Canadian Cancer Society as  
20 a whole, across Canada.

21 THE CHAIRMAN: Then it came from  
22 public subscriptions?

23 DR. WARWICK: From the public only.

24 THE CHAIRMAN: I suppose it is not  
25 unfair to acknowledge that the money is in part tax  
26 money. It is money that would have been paid in taxes  
27 which is otherwise diverted to gifts? It is one of  
28 those things we cannot overlook entirely.

29 DR. WARWICK: I don't think I under-  
30 stand your point.

THE CHAIRMAN: Tax exemption?

DR. WARWICK: Yes sir.



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 field some four years before the National Cancer  
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 very active cancer research programs.

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 which is otherwise devoted to gifts? It is one of  
 those things we cannot overlook entirely.

DR. WATKIN: I don't think I understand

stand your point.

DR. WATKIN: Yes sir.



Warwick

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3 THE CHAIRMAN: It has the effect of  
4 diverting money that would otherwise go to the Treasury,  
5 go in as taxes?

6 DR. WARWICK: Partially.

7 THE CHAIRMAN: Partially, but not  
8 entirely. Now, are there many other such institutions  
9 as the one on the Saskatoon campus, which is apparently  
10 quite an institution?

11 DR. WARWICK: Sir, there is one in  
12 British Columbia comparable in size, a little larger;  
13 one in Alberta; one in Saskatoon. The Manitoba Cancer  
14 Foundation does not have a comparable institution.  
15 There is a similar institution or institute on the  
16 grounds of the University of Western Ontario. There  
17 is in Toronto what is called the Ontario Cancer  
18 Institute in Princess Margaret Hospital. That is a  
19 more difficult situation to explain.

20 THE CHAIRMAN: We could get Mr.  
21 McCutcheon to explain that.

22 DR. WARWICK: Under the auspices of  
23 the cancer foundation. In Montreal support is given  
24 to what is known as the Montreal Cancer Society which  
25 is housed in the Notre Dame Hospital. Those are the  
26 only institutions.

27 THE CHAIRMAN: Nothing in the Atlantic  
28 provinces?

29 DR. WARWICK: No, sir.

30 THE CHAIRMAN: Dr. Baltzan, have you  
some questions?

COMMISSIONER BALTZAN: Just one point





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THE CHAIRMAN: It is the object of  
 directing them that would otherwise be the property,  
 in the case of  
 THE CHAIRMAN: Similarly,  
 THE CHAIRMAN: Similarly, but not  
 entirely. Now, are there any other such institutions  
 as the one on the opposite side, which is apparently  
 quite an institution?  
 THE CHAIRMAN: Yes, there is one in  
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 one in Alberta; one in Saskatchewan. The Ontario Cancer  
 Foundation does not have a comparable institution.  
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 Province of the University of Western Ontario. There  
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 to what is known as the Montreal Cancer Society which  
 is housed in the Notre Dame Hospital. There are other  
 very institutions.  
 THE CHAIRMAN: Nothing in the Atlantic  
 provinces?  
 THE CHAIRMAN: Yes, sir.  
 THE CHAIRMAN: Yes, but have you  
 a question  
 THE CHAIRMAN: Yes, sir.





Warwick

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of explanation, the Canadian Tumour Registry, does that operate on a national basis or a provincial basis?

DR. WARWICK: Dr. Baltzan, this is a registry in the sense of pathology of tumours. It is not a registry of cancer cases, and the unusual cases are sent there for their opinion, and then farmed out to institutions across Canada. They have a collection of special tumours, teaching sets and the like. It is national in that sense.

THE CHAIRMAN: They don't take average specimens that the physician could pick up in his office or in the hospital?

DR. WARWICK: No, sir.

COMMISSIONER FIRESTONE: Dr. Warwick, in paragraph 26 on page 15, you speak of the liberalization of methods of making federal, provincial grants has contributed to an increase of such grants. You mentioned \$271,000 as representing the total grants received in the fiscal year 1960 to 1961. Can you explain to us why this liberalization led to decreases to the extent of \$234,000. in 1961-1962 and to approximately \$240,000. in the fiscal year 1962-1963. Does liberalization mean reducing grants?

DR. WARWICK: I would like to have Mr. Pifher answer this.



of explanation, the American Through History, that the  
creation of a national basis on a provincial basis

a reaction in the sense of psychology of its own, it  
is not a reaction of common sense, and the usual of sense  
and sense there for their own, and the common one  
to institutions common sense, they have a collection  
of actual time, technical side and the like. It is  
national in that sense.

THE CHAIRMAN: "They don't take average  
and mean that the physician could pick up in his office  
on the hospital?"

in the speech he on page 11, you speak of the international  
of nations of making today, provincial and so on  
contrasted to an increase of such general, you mentioned  
1947, as representing the total of data received in  
the first year 1947 to 1948. Can you explain to me  
what this information led to data seen to the extent  
of 1947, in 1948-49 and to approximately 1947, 1948  
in the total of 1947-48. Does information then mean

Dr. [Name] : "I would like to have



Pifher

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4 MR. PIFHER: Well, the liberalization  
5 isn't working out actually. There was a proposal made  
6 by the Department of National Health and Welfare some  
7 two years ago to the provincial governments that the  
8 basis of the grant to the National Cancer Institute be  
9 increased from 7% to 10% of the federal grants for  
10 cancer control, which, if all provinces had taken it up,  
11 would have given the National Cancer Institute 350,000  
12 dollars a year.

13 Prior to that the grant to the Institute  
14 was a matching one. The Federal Government said, we  
15 will give 3.1/2% if you will do likewise. That meant  
16 that it had to come to us through the Provincial Govern-  
17 ment, who had to make a contribution dollar for dollar.

18 Under the liberalization plan the Depart-  
19 ment said the 10% will be paid entirely from the federal  
20 share of the cancer grant taken off the top. That was  
21 not very popular with the Provincial Governments, and  
22 you can understand why, because it actually lessened  
23 the amount of money that they had available for their  
24 programs, so they, in the one year of the successful  
25 operation of the grants, were increased to approximately  
26 275,000 dollars total, with several provinces agreeing  
27 to the 10% arrangement.

28 But in the second year of it most of  
29 them reverted to the old arrangement, and in addition  
30 we lost one provincial grant, so there was a short fall  
over the previous year of 150,000 dollars income.

COMMISSIONER FIRESTONE: In the third  
year you are estimating 240,000 dollars. Can you tell







Pifher

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us how much is coming from federal sources?

MR. PIFHER: We would say that is dollar to dollar, so that half would be federal and half provincial.

COMMISSIONER FIRESTONE: Or approximately 120 to 125 thousand federal funds?

MR. PIFHER: That is right.

COMMISSIONER FIRESTONE: You consider this is an inadequate contribution to a research program and research efforts that are required in this field, do you?

MR. PIFHER: Yes.

COMMISSIONER FIRESTONE: Have you given consideration as to what would be an adequate research program in this field, in terms of amounts?

MR. PIFHER: Yes, the proposal that was made to the Department of National Health and Welfare last Fall was that for a beginning the basis of support might start with 25% of our budget, which would -- our budget then was estimated at 1,600,000, which would increase the federal grant to 400,000 dollars a year, and that this should not be at the expense of the provincial program. In other words, we requested that this grant be paid to us direct, and increase with our budget.

COMMISSIONER FIRESTONE: In other words, your proposal, if I understand you correctly, you are really not satisfied with the existing matching system of federal-provincial grants in the field of research. You would like to see the Federal Government make a direct contribution to your research program at a given



as now time is coming from federal sources?

MR. FLEMMING: We would say that is doing

to deliver, so that half would be federal and half provincial

COMMISSIONER FLEMMING: Or approximately

1950 to 1955 thousand federal families?

MR. FLEMMING: That is right.

COMMISSIONER FLEMMING: You understand

this is an independent contribution to a research program

and research efforts that are required in this field,

do you?

MR. FLEMMING: Yes.

COMMISSIONER FLEMMING: Have you

given consideration as to what would be an adequate

research program in this field, in terms of amounts?

MR. FLEMMING: Yes, the proposal that

was made to the Department of National Health and

Welfare last Fall was that for a beginning the field

of support might start with 45% of our budget, which

would -- our budget then was estimated at \$1,600,000,

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not satisfied with the existing matching system

of federal-provincial grants in the field of research.

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direct contribution to your research program at a given



Warwick

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amount. Is that the system you advocate?

DR. WARWICK: Yes, sir.

THE CHAIRMAN: And you take your chances of getting what you can from the province?

DR. WARWICK: Well, it is clear from what has been said up till now that what we receive from federal and provincial sources is conditional on the actions of provincial governments, which change from year to year.

COMMISSIONER FIRESTONE: And you feel that you would like to see really a new approach to the financing of research in the cancer field, that you would like to obtain a minimum grant from the Federal Government, and then try to obtain additional sums from provincial governments, and private sources. Is that the way you plan to go about it?

MR. PIFHER: It was not our plan to continue our approach to the provincial governments if we could make a satisfactory direct financial arrangement with the Federal Government. We would then be out of the area of competing with provincial governments as regards their own programs in relation to our program.

DR. TAYLOR: On page 17 we have suggested a parallel. The burden of this brief is that the suggestion that the Federal Government increase its support of the cancer research program of the Institute in a manner parallel to the increasing support of other areas of medical research. Each year representatives of the Institute sit with representatives of the Defence Research Board, Department of Veterans' Affairs, the





...is that the system you advocated

THE CHAIRMAN: And you have

chances of getting what you can from the Government?

DR. WILKINSON: Well, it is clear that

what has been said up till now that what we require

from Federal and provincial sources is conditional on

the actions of provincial governments, which cannot

from year to year.

COUNTESS JAMES TILLY: And you feel

that you would like to see really a new approach to the

financing of research in the cancer field, that you

would like to obtain a minimum grant from the Federal

Government, and then try to obtain additional sums from

provincial governments, and private sources. Is that

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MR. FLETCHER: It was not our plan to

continue our approach to the provincial governments if

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with the Federal Government. We would then be out of

the mess of competing with provincial governments for

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suggested a parallel. The burden of this bill is that

the suggestion that the Federal Government should

support of the cancer research program of the Institute

in a manner parallel to the increasing support of other

fields of medical research. Each year the research

of the Institute of Cancer Research of the University

Research Board, Government of Canada, and the



Taylor

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3 Medical Research Council and Department of National  
4 Health and Welfare, and at that time the Institute  
5 assumes responsibility for any area of research which  
6 seems to be in the field of cancer, and therefore, the  
7 Federal Government has, in effect, declared us to be  
8 its instrument in the field of support of cancer research  
9 and we are suggesting that had the Government's increase  
10 in support of the Institute's program been in parallel  
11 with the increase given to other areas of medical  
12 research, that on the basis of total support given to  
13 medical research, our annual resources from the Federal  
14 Government would be 1,800,000, and if it were in  
15 parallel only with the increased support to the Medical  
16 Council program, it would be 1,400,000 dollars.

16 COMMISSIONER FIRESTONE: Well, I am  
17 very grateful to you for drawing our attention to these  
18 two figures. They are very helpful, because they set  
19 out the sort of range of a research budget in the field  
20 of cancer, and what I am trying to establish, sir, is  
21 what you, as an Association, would feel is the desirable  
22 budget for cancer research for Canada.

22 Is it 400,000? Is it 1.4 million? Is  
23 it 1.8 million? What do you, in your wisdom and experience,  
24 consider a desirable amount of funds to be spent construc-  
25 tively and helpfully in this important field?

25 DR. WARWICK: Mr. Chairman, this is not  
26 an easy question to answer. I think that any research  
27 program can expand only as facilities, money and trained  
28 personnel come into the picture. Huge amounts of money  
29 all at one time will not solve the problem, and I think  
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Medical Research Council and Department of National  
Health and Welfare, and at that time the Minister  
assumes responsibility for any error. I research which  
want to be in the field of cancer, and therefore, the  
Federal Government has, in effect, declined to do  
its investment in the field of support of cancer research  
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in support of the Institute's program been in parallel  
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of cancer, and what I am trying to establish, etc., is  
that you, as an association, would feel in the position  
to support for cancer research for health.  
Is it \$1,400,000? Is it \$1.5 million? Is  
it \$1.8 million? That is you, in your wisdom and experience,  
consider a desirable amount of funds to be spent collectively  
and help in that important field.  
Dr. HENRY J. HARRISON, this is not  
an easy question to answer. I think that any research  
program can expand only as facilities, money and training  
are added into the picture. The amount of money  
at one time will not solve the problem, and I think





Warwick

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3 it is fair to say, Mr. Pifher can correct me, that the  
4 budget of the National Cancer Institute has been  
5 increasing at approximately what rate a year?

6 MR. PIFHER: 20 to 25%.

7 DR. WARWICK: 20 to 25% a year. I  
8 don't know if the Commission would be interested in  
9 knowing, but in the country to the south of us we do  
10 know some figures there, and Great Britain, but we do  
11 know that support for cancer research from the United  
12 States, as is mentioned on page 16 of the brief, for  
13 their National Cancer Institute from federal sources  
14 is 142 million dollars.

15 Now, if this source, comparing the  
16 size of our two countries on a population basis, it  
17 might mean in Canada, would it not, be somewhere in  
18 the region of 14 million dollars, so it falls far short  
19 of that; therefore, I feel it fair to say, sir, that  
20 the support the National Cancer Institute is giving to  
21 people to do research, and the support given through  
22 the Cancer Foundation, I feel that what can be done is  
23 being done at the present time, but this will expand.

24 COMMISSIONER FIRESTONE: You are  
25 quoting those figures for the United States, and you  
26 say if we were to spend the same amount on a per capita  
27 basis, it would work out at roughly 14 million dollars.

28 If you spent 10% of what the United  
29 States is spending on a per capita basis, it would work  
30 out at 1.4 million, which is in your paragraph 30 on  
page 17, but what you are doing at the moment is, you  
are spending 1% per capita approximately of what the

It is true that, Mr. [Name] can correct it, that the  
subject of the National Cancer Institute was a  
[Name] at approximately what date a year?

Mr. [Name]: 30 to 35.

Mr. [Name]: 10 to 15 a year.

I don't know if the [Name] could be interested in  
[Name], but in the course of the study of us we do  
know some things there, and about [Name], but we do  
know that support for cancer research from the [Name]  
[Name], as is mentioned on page 16 of the paper, for  
[Name] with a [Name] [Name] from federal sources.  
as [Name] [Name].

Now, if this source, concerning the

size of the two countries on a population basis, is  
[Name] in 1964, using it not, no somewhere in

the region of 14 million dollars, so it tells for about  
[Name]; therefore, I feel it is fair to say, also, that

the support of the National Cancer Institute is giving to  
people to do research, and the support given through

the Cancer Foundation, I feel that what can be done is  
being done at the present time, but this will [Name]

CONFIDENTIAL: [Name]

Nothing more [Name] for the United States, and you

and it was to spend the same amount on a per capita  
basis, to work out at roughly 14 million dollars.

If you are at all of that the [Name]

studies to spend a on a per capita basis, it would work  
out as a [Name] [Name] in your [Name] 30 or

page, but what you are doing at the moment is, you

are [Name] [Name] [Name] [Name]



Warwick

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United States is spending. Is that adequate?

DR. WARWICK: Well, we could certainly spend more, sir. The applications that come to us annually are several hundred thousands more than we can support, and it is a matter of cutting and trimming here to make the monies go around.

COMMISSIONER FIRESTONE: Yes, that is exactly the point. You could spend a good deal more, and you have to restrict your research program because of the inadequacy of funds, not because you don't have research associates or scientists that want to work in the field and are competent to do so.

Would not the effect of the inability to finance programs be that some of those scientists and experts are moving to the south to do the research, because they have not got the opportunities and financing in Canada; is that true?

DR. WARWICK: This is true to a certain extent. I think that with additional funds we could expand our program more rapidly, and take into the picture the younger chaps that are being trained to be independent investigators.

COMMISSIONER FIRESTONE: What would you consider a desirable program of research in the field of cancer in Canada in the initial period? Would it be 400,000, a million point four, a figure in between? What is your own view?

DR. WARWICK: If you are asking my own view, sir, the National Cancer Institute is spending approximately 1.1/2 million. The Ontario Cancer





United States is according to that report.

DR. WARWICK: Well, we have certainly

spent more, sir. The applications that come to us annually are several hundred thousand more than we can support, and it is a matter of sorting and selecting them to make the most as we should.

DR. WARWICK: Yes, that is

exactly the point. You could spend a good deal more, and you have to restrict your research program because of the inadequacy of funds, not because you don't have research associates or scientists that want to work in the field and are competent to do so.

Would not the effect of the inability

to finance programs be that some of those scientists and experts are moving to the south to do the research, because they have not got the opportunities and financing in Canada; is that true?

DR. WARWICK: This is true to a certain

extent. I think that with additional funds we could

expand our program more rapidly, and take into the whole the younger class that are being trained to do independent investigations.

DR. WARWICK: What would

you consider a desirable program of research in the field of cancer in Canada in the initial period? Would it be \$100,000, a million point four, a figure in between that is your own view?

DR. WARWICK: If you are asking my

view, sir, the National Cancer Institute is spending approximately \$1.12 million. The Ontario Cancer



Warwick

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Foundation must be close to 1 million dollars this year. I would think, at the present time, that one-and-a-half times this amount could be spent, sir, and that with additional funds there could be a more rapid expansion of cancer research.

COMMISSIONER McCUTCHEON: One-and-a-half times what amount, Dr. Warwick?

DR. WARWICK: 2.1/2 million.

COMMISSIONER McCUTCHEON: Are you saying that you could spend an additional one-and-a-half times 2.1/2 million?

DR. WARWICK: I think if we had 50% more than the total amount available at the present time that it could be spent, sir.

COMMISSIONER McCUTCHEON: So you are saying you could spend another million-and-a-quarter?

DR. WARWICK: Yes, sir. I would like to ask you though, sir, that is personal opinion, whether Dr. Taylor agrees with me.

COMMISSIONER McCUTCHEON: You see every application that comes to the Defence Research Board, the Medical Research Council, or directly to the Institute, or that involves the cancer field. Is that right, Dr. Taylor?

DR. TAYLOR: Yes.

COMMISSIONER McCUTCHEON: Well, last year, can you tell me what the price tag was on the ones that you turned down, that you turned down for lack of money, not because you felt that they were not good applications?



expansion must be close to 2 million dollars this year. I would think, at the present time, that one-and-a-half times this amount would be spent, sir, and that with additional funds there would be a more rapid expansion of research.

Well, sir, the amount, Dr. Wainick?

Dr. Wainick: 2.5 million.

COMMISSIONER MONTGOMERY: And you

feeling that you could spend an additional one-and-a-half

Dr. Wainick: I think if we had 500

more than the total amount available at the present time that it would be spent, sir.

COMMISSIONER MONTGOMERY: So you are

saying you could spend another million-and-a-half?

Dr. Wainick: Yes, sir. I would like

to ask you though, sir, that is personal opinion,

whether Dr. Taylor agrees with me.

COMMISSIONER MONTGOMERY: You see

every scientist or that comes to the National Research

Council, the Federal Research Council, or three or four

institutions, or that involves the cancer field. In that

light, Dr. Taylor?

Dr. Taylor: Yes.

COMMISSIONER MONTGOMERY: Well, that

is, when you tell me that the price tag was 2.5

one year and turned down, that you turned down for lack

of money, not because you felt that they were not good





Taylor

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4 DR. TAYLOR: It is hard to put a figure  
5 on that, because when we start to look at the applica-  
6 tions we know that we have applications this year for  
7 a total of about 4 to 5 hundred thousand dollars more  
8 than we have funds, and therefore we unconsciously set  
9 in our minds a determination to be particularly tough  
10 in the scrutiny of the applications, and anything that  
11 seems to fail in any way is turned down.

12 COMMISSIONER McCUTCHEON: Are you  
13 saying that this year, if you were to accept all the  
14 applications, you would need another 4 to 5 hundred  
15 thousand dollars?

16 DR. TAYLOR: Yes, sir.

17 COMMISSIONER McCUTCHEON: Well, that  
18 gives me an indication.

19 COMMISSIONER FIRESTONE: Would you  
20 like to expand?

21 DR. TAYLOR: There is more to it. I  
22 think at the time the National Cancer Institute was  
23 first established there was very little cancer research  
24 being carried on in the country. The only agency in  
25 Canada, I think, that was really supporting research  
26 in cancer was the Ontario Cancer Treatment and Research  
27 Foundation, and its efforts were in Ontario. I think  
28 that interest in research and applications for support  
29 of research tend to increase if money becomes available,  
30 and furthermore, programs can be changed and there are  
certain areas of programs in support of cancer research  
which the Institute couldn't look at at all now because  
it does not have the finances to begin to consider them.



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Taylor

DR. TAYLOR: It is hard to put a figure

on that, because when we start to look at the applications we know that we have applications this year for a total of about \$400,000, and therefore we unconsciously set in our minds a determination to be particularly tough in the scrutiny of the applications, and anything that seems to fall in any way is turned down.

COMMISSIONER MORTIMER: Are you

saying that this year, if you were to accept all the applications, you would need another \$400,000 to \$500,000?

Gives me an indication.

COMMISSIONER FINESTONE: Would you

like to expand?

DR. TAYLOR: There is more to it. I

think at one time the National Cancer Institute was the only established there was very little cancer research being carried on in the country. The only agency in Canada, I think, that was really supporting research in cancer was the Ontario Cancer Treatment and Research Board, and its efforts were in Ontario. I think that interest in research and applications for support of research tend to increase if money becomes available, and furthermore, programs can be changed and there are certain areas of programs in support of cancer research which the Institute couldn't look at at all now because it does not have the finances to begin to consider them.



Taylor

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There would be a lag.

DR. WARWICK: When I referred to the money available from federal sources in the United States, that is the money available alone from federal sources in the States. In addition to that, there are very large sums of money, the equivalent and more, coming from organizations such as the American Cancer Society.

COMMISSIONER FIRESTONE: I think you made your point clear, and we understood it in the manner in which you have just explained it now. To come back to the matter of the point of what is a desirable budget for cancer research in Canada: do I understand you correctly, gentlemen, that if Canada would have an initial research budget for cancer research of 1.1/4 million dollars, and this amount, given two or three years for the program to develop, could be spent constructively and usefully, and in this field; am I right in this understanding?

DR. WARWICK: Yes, sir.

COMMISSIONER FIRESTONE: Is your second recommendation that this amount should be made available by the Federal Government?

DR. WARWICK: You are referring to additional amounts? We are spending 1.1/2 million dollars now.

COMMISSIONER FIRESTONE: Is this million-and-a-half all for research, and is this million-and-a-half paid by the Federal Government?

DR. WARWICK: The present





income would be a loss.

Dr. WARWICK: When I referred to the

money available from Federal sources in the United States, that is the money available from Federal sources in the States. In addition to that, there are very large sums of money, the equivalent and more,

coming from organizations such as the American Cancer

COMMITTEE TO ERADICATE CANCER: I think you

made your point clear, and we understood it in the hearing which you have just explained it now. To come back to the matter of the point of what is a testable subject for cancer research in Canada; do I

would have a realistic research budget for cancer research of 1.1 million dollars, and this amount, given for three years for the program to develop, could be spent constructively and usefully, and in this field; and I trust in this understanding.

COMMITTEE TO ERADICATE CANCER: Is your

and no recommendation that this amount should be made available by the Federal Government?

Dr. WARWICK: You are referring to

that amount? We are spending 1.1 million

million-and-a-half for research, and is this

million-and-a-half for the Federal Government?

Dr. WARWICK: The present



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Warwick

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million-and-a-half being paid?

COMMISSIONER FIRESTONE: Yes.

DR. WARWICK: 85% of that comes from the Canadian Cancer Society. 15% comes from federal-provincial sources.



million-and-a-half being paid

COMMISSIONER

DR. WARWICK: 828 of that comes from

158 comes from federal

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COMMISSIONER FIRESTONE: Fine. Now, therefore, your suggestion is that we could absorb a program one and a quarter million dollars greater than the present program given two or three years to implement such a program?

8

DR. WARWICK: Yes.

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COMMISSIONER FIRESTONE: Would your recommendation be that one-quarter of this one and a quarter million dollars would come from federal sources?

11

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DR. WARWICK: Yes, sir.

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COMMISSIONER FIRESTONE: The federal government is already contributing at the moment \$125,000, what you are saying, if I understand you correctly, that you are recommending a total federal government grant of approximately 1.4 million dollars; is that correct?

18

DR. WARWICK: Yes, sir.

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COMMISSIONER FIRESTONE: For research purposes?

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DR. WARWICK: Yes, sir.

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COMMISSIONER FIRESTONE: Thank you very much.

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DR. WARWICK: It is not the suggestion that you pay an amount to be established and remain fixed, it would be understood it might grow as the cancer research program developed along with the expansion of medical research generally.

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COMMISSIONER FIRESTONE: It is your belief that presumably some allowance for the growth of the program in line with medical research generally should

COMMISSIONER FIRSTONE: Yes, sir.

There is, what suggestion is that we could a  
program one and a quarter million dollars greater than  
the present program given two or three years to  
such a program?

DR. WARWICK: Yes.

COMMISSIONER FIRSTONE: Would you?

Recommendation is that one-quarter of this one and a  
quarter million dollars would come from Federal sources?

DR. WARWICK: Yes, sir.

Government is already contributing at the moment  
\$125,000, what you are saying, if I understand you  
correctly, that you are recommending a total Federal  
government grant of approximately 1.4 million dollars;  
is that correct?

DR. WARWICK: Yes, sir.

COMMISSIONER FIRSTONE: For research

proposed?

DR. WARWICK: Yes, sir.

COMMISSIONER FIRSTONE: Thank you.

Very much.

DR. WARWICK: It is not the suggestion

that you pay an amount to be established and remain

fixed, it would be understood it might grow as the

other research program developed along with the growth

of medical research generally.

COMMISSIONER FIRSTONE: It is your

belief that presumably some allowance for the growth of

the program in line with medical research generally is



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3 be made?

4 DR. WARWICK: Yes.

5 COMMISSIONER McCUTCHEON: You could  
6 not spend one and a quarter million dollars in the first  
7 year?

8 DR. WARWICK: I do not think we could.

9 COMMISSIONER FIRESTONE: Could you  
10 spend it in two or three years given time to develop  
11 the program?

12 DR. TAYLOR: I think we could, yes.

13 COMMISSIONER McCUTCHEON: You have  
14 referred to the United States figures, do you agree with  
15 a view that I have heard expressed a good deal that the  
16 research done in the United States is done on an  
17 extravagant and may be not as effective or efficient  
18 basis as it could be?

19 DR. WARWICK: I would be reluctant to  
20 express an opinion on that publicly, sir.

21 COMMISSIONER McCUTCHEON: That is  
22 your answer.

23 THE CHAIRMAN: Thank you very much,  
24 gentlemen.

25 THE SECRETARY: The next submission  
26 will be that of the Ontario Cancer Treatment and Research  
27 Foundation and it will be known as exhibit 283.

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30 ---EXHIBIT NO. 283:

Submission of Ontario  
Cancer Treatment and  
Research Foundation.





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COMMISSIONER MONTGOMERY: You could

not spend one and a quarter million dollars in the first

year?

DR. WATKINS: I do not think we could.

COMMISSIONER MONTGOMERY: Could you

spend it in two or three years given time to develop

the program?

DR. TAYLOR: I think we could, yes.

COMMISSIONER MONTGOMERY: You have

referred to the United States figures, do you agree with

a view that I have heard expressed a good deal that the

research done in the United States is done on an

extravagant and may be not as effective or efficient

basis as it could be?

DR. WATKINS: I would be reluctant to

express an opinion on that publicly, sir.

COMMISSIONER MONTGOMERY: That is

your answer.

THE CHAIRMAN: Thank you very much.

THE SECRETARY: The next session

will be that of the Ontario Cancer Treatment and Research

Foundation and it will be known as exhibit 2.

Submission of Exhibits

---EXHIBIT NO. 283

Research Foundation



SUBMISSION OF  
THE ONTARIO CANCER TREATMENT AND  
RESEARCH FOUNDATION

APPEARANCES:

Mr. John Law  
Dr. W.G. Cosbie  
Mr. J.H. Broughton

DR. COSBIE: We prepared a summary of our brief and I might say that under the heading one it has to do with the fact that in 1943 the Ontario Cancer Foundation was incorporated by the government of the Province of Ontario carrying out a program of cancer research, administering treatment, the welfare of cancer patients and we have carried on that program ever since.

The great value of Federal and matching Provincial cancer control grants in developing the radiation treatment centres of the Foundation including the Princess Margaret Hospital, to their present state is stressed.

The advantages of an organization such as the Foundation in administering, guiding and co-ordinating a cancer control programme for the Province are described.

The role of the Foundation in providing funds for the financing of the construction of new and enlarged clinics throughout the Province is mentioned. This applies to the Princess Margaret Hospital to only a minor extent as the Government of the Province of Ontario contributed eighty-seven per cent of the cost of







Cosbie

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construction of and additions to the Institute.

The very strong arguments in favour of a policy of centralization of facilities for radio-therapy are enumerated.

The value of hostel accommodation adjacent to radiation treatment centres is explained.

The provision of chemotherapeutic agents under a controlled system and with some regard to avoiding unnecessary expense is proving satisfactory to an increasing number of physicians and their patients.

The extent of the research programme of the Foundation and of The Ontario Cancer Institute is outlined. Again, the value of Federal and matching Provincial cancer control grants in making possible a tremendous expansion in the research programme is stressed.

The importance of adequate training programmes for radio-therapists, radiophysicists and radiotherapy technicians is emphasized.

#### Recommendations

In view of the tremendous contribution to the cancer control programme made by Federal and Provincial cancer control grants, it is submitted that these grants should be increased somewhat, possibly proportionately to the increase in population since they were introduced.

A policy of centralization of facilities for treatment of cancer by radiotherapy, should be followed despite the pressure towards decentralization resulting from the introduction of hospital insurance plans involving payment for radiotherapy.





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4 The concept of hostel accommodation  
5 in association with general hospitals and as a substitute  
6 for expensive hospital beds for those patients not  
7 requiring intensive medical and nursing care, should  
8 be seriously considered by the proper authorities.

9 The treatment of cancer patients in  
10 Ontario by radiotherapy during the past several years,  
11 has only been accomplished with the assistance of quite  
12 a number of very well trained British radiotherapists  
13 who have immigrated to Canada. To ensure a supply of  
14 Canadian doctors, choosing to specialize in radio-  
15 therapy, it is recommended that the facilities of the  
16 Foundation's Clinics and of the Princess Margaret  
17 Hospital, be used to a considerably greater extent by  
18 the medical schools in outlining the place of  
19 radiotherapy in the management of cancer to medical  
20 undergraduates.

21 THE CHAIRMAN: Thank you very much,  
22 Dr. Cosbie.

23 COMMISSIONER FIRESTONE: Dr. Cosbie,  
24 you heard the discussion that preceded the submission  
25 of your brief and Dr. Warwick and his associates mentioning  
26 the desirability of increased federal assistance to a  
27 research program in the field of cancer research. The  
28 figure that was mentioned was \$1.4 million as a federal  
29 government contribution to such a research program  
30 and that this payment would be an initial payment to  
be extended gradually over time as research facilities  
expanded and worthwhile research projects were being  
brought forward. Would you support such a research





The concept of hostel accommodation

in association with general hospitals and as a substitute for extensive hospital beds for these patients not requiring intensive medical and nursing care, should be seriously considered by the proper authorities.

The treatment of cancer patients in

Ontario by radiotherapy during the past several years, has only been accomplished with the assistance of a number of very well trained British radiotherapists who have immigrated to Canada. To ensure a supply of Canadian doctors, desirous to specialize in radiotherapy, it is recommended that the facilities of the Princess Margaret

Hospital, be used to a considerably greater extent in the medical schools in outlining the place of radiotherapy in the management of cancer to medical

undergraduates.

THE CHAIRMAN: Thank you very much.

Dr. Gossie.

COMMISSIONER FLETCHER: Dr. Gossie,

you heard the discussion that preceded the submission of your brief and Dr. Fletch and his associates representing the responsibility of proposed federal assistance to a research program in the field of cancer research. The figure that was mentioned was \$1.4 million as a federal government contribution to such a research program and that this payment would be an initial payment to be followed gradually over time as research facilities expanded and worthwhile research projects were being brought forward. Would you support such a research



Cosbie

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program and the amounts that have been mentioned?

DR. COSBIE: Dr. Firestone, representing the Foundation, the one thing that we would be very anxious not to have disturbed in any way would be the basis on which provincial and federal matching cancer control grants are administered. At the present time we have expanded our program in Ontario to the limit of available funds and if anything jeopardized the proportion of payments of those grants in support of what is known as cancer control, it would be disastrous to us. What the National Cancer Institute wants to appeal to the government for above what they get now that is their own business and as one who has seen the development of cancer research, I agree you cannot stand still with regard to government support.

COMMISSIONER FIRESTONE: In other words, you would visualize that whatever arrangements are being worked out to provide additional federal funds for cancer research they should not interfere with the existing research for cancer control but from the support your own association has given to research in particular areas, because you have a division of labour with the National Cancer Institute, you would feel that perhaps considerably more should be done in the field of cancer research than is presently the case in Canada. Am I right in that understanding?

DR. COSBIE: Absolutely.

COMMISSIONER FIRESTONE: And you feel that amounts of the order that have been suggested by the National Cancer Institute of Canada if they were able







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3 to obtain such funds from the federal government this  
4 would be a desirable thing to do in Canada?

5 DR. COSBIE: I think there is no  
6 doubt about that. I think I would like to point out  
7 that our bill, the amount of money that the Ontario  
8 Cancer Foundation is putting into research in the next  
9 year will be \$1,200,000. Now, that is over and above  
10 anything that they are faced with and we do know that  
11 the expansion in research is just tremendous.

12 COMMISSIONER FIRESTONE: It is tremen-  
13 dous and highly desirable?

14 DR. COSBIE: Oh, absolutely.

15 COMMISSIONER BALTZAN: I would  
16 appreciate if you could quickly give me the tie-up or  
17 inter-relationship between the organizations that we  
18 have had here today, the National Cancer Institute, the  
19 Canadian Cancer Society and your body.

20 DR. COSBIE: Where would you like me  
21 to start?

22 COMMISSIONER BALTZAN: Just where you  
23 are sitting.

24 DR. COSBIE: In Canada the administra-  
25 tion of health is a provincial matter and on that basis  
26 in 1947 the Ontario Government set up this Foundation  
27 -- 1943, I should say. Now, four years later because  
28 it was properly deemed a development that was in every  
29 way justified, the Federal Government set up the  
30 National Cancer Institute and my understanding of their  
chief function was that they were to co-ordinate the  
basic research across Canada. You must realize there are



to obtain such funds from the Federal government this

would be a desirable thing to do in Canada?

MR. COBBIE: I think there is no

doubt about that. I think I would like to point out

that our bill, the amount of money that the Ontario

Cancer Foundation is putting into research in the next

year will be \$1,700,000. Now, that is over and above

everything that they are faced with and we do know that

the expansion in research is just tremendous.

COMMISSIONER FLETCHER: It is there-

does and highly desirable?

MR. COBBIE: Oh, absolutely.

COMMISSIONER BARTON: I would

appreciate if you could quickly give me the reason or

inter-relationship between the organizations that we

have had here today, the National Cancer Institute, the

Canadian Cancer Society and your body.

MR. COBBIE: Where would you like me

to start?

COMMISSIONER BARTON: Just where you

are sitting.

MR. COBBIE: In Canada the a similar-

tion of research is a provincial matter and on that basis

in 1947 the Ontario Government set up this foundation

-- I think says, "Now, four years later because

it was properly deemed a development that was in every

way justified, the Federal Government set up the

National Cancer Institute and my understanding of their

work is that they were to coordinate the

research across Canada. You can see there are



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3 two types of cancer research, there is cancer research  
4 which looks after the cause and cure of cancer and then  
5 there is the cancer research that cannot be disassociated  
6 from a treatment organization such as ours and this  
7 has to do with developing better methods of treatment.  
8 That is why it is over the years that in Ontario we have  
9 continued to support all the clinical research that is  
10 done in Ontario while the National Cancer Institute,  
11 so far as Ontario is concerned, supports all the basic  
12 research it did until the Ontario Cancer Institute was  
13 built. Now, the Canadian Cancer Institute is a  
14 provincial development.  
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Now, the Ontario Cancer Institute is a provincial development, purely a provincial development, and the Ontario Cancer Foundation, which is the provincial organization which handles the matching cancer control grants, provides all the money that pays the basic salaries for all the staffs of the Ontario Cancer Institute.

When I say our expenses will be \$1,200,000 for research next year, that includes those salaries, it includes the grants which we have never failed to pay to the National Institute, which is approximately \$85,000 each year; it also includes \$380,000 which is spent on clinical research projects, physiotherapy and radiotherapy and chemotherapy.

COMMISSIONER BALTZAN: I was thinking of the inter-relationship, and my question is based upon the element of likely re-duplication of any efforts or any overlapping.

DR. COSBIE: No.

COMMISSIONER BALTZAN: That doesn't happen in any case. My reason for saying that - I didn't want to be inquisitive - is because when I look at the organization of the Canadian Cancer Society I think three features parallel in their statement or Letters Patent; one having to do with research, and the other having to do with research, one having to do with maintaining establishments and the other along the same lines. So when one reads things the way they are written, the question is whether there is any overlapping.

I have faith enough to believe that







Cosbie

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there isn't; it is a good co-ordinating effort on the part of the provincial and the national institutes.

DR. COSBIE: All the applications for grants in aid for research that we receive are paid to the office of the National Cancer Institute and they also pass on their applications to us. But we don't have anything to do with the Ontario research organizations except in Hamilton, where there are Ph.D.'s who do research.

COMMISSIONER BALTZAN: You emphasize particularly radiation and also chemotherapy and not surgery. Now, these radiation therapy measures, how are they provided? Let's speak of radiation.

DR. COSBIE: If I could have Mr. Broughton deal with that, he could tell you better.

MR. BROUGHTON: Mr. Chairman, the patients who are hospitalized have their radiation therapy covered by the Ontario Hospital Services plan which covers, I believe, about 98% of the population. The out-patients are charged a fee which is roughly one-half to one-third of the cost of the treatment.

If there is any question of their inability to pay or hardship be incurred by imposing the charges we make all reasonable efforts to determine whether the patient should pay or not. In many cases, we don't charge at all.

COMMISSIONER BALTZAN: You don't charge or you apply to welfare organizations?

MR. BROUGHTON: No, we just absorb the cost.



these things, it is a good organization; and the  
and of the medical and the national institutes.  
DR. COOPER: All the applications  
for grants in and for research that we receive are  
sent to the staff of the National Cancer Institute  
and they also pass on these applications to us, but  
we have not yet had to do with the Cancer Research  
institutions except in Hamilton, where there are  
F.D.C.'s who do research.

COMMISSIONER BARTON: You emphasize

particularly the staff and also chemotherapy and not  
surgery, but those are the therapy measures, how  
are they provided? Part of the radiation

DR. COOPER: If I could have the

program, I think that, he could tell you better.

DR. COOPER: If I could have the

patients who are hospitalized have their radiation  
therapy, covered by the Federal Hospital Services plan  
and, I believe, about 88% of the population.  
The outpatients are covered a fee which is roughly  
one-half to one-third of the cost of the treatment.  
If there is any question of their

ability to pay or how it is covered by insurance,

the charges are not all covered by efforts to determine  
whether the patient should pay or not. In many cases,  
we have a way of doing it.

COMMISSIONER BARTON: You don't know

if you have to wait for a certain time

Dr. Cooper: No, we just around the



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Broughton

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COMMISSIONER BALTZAN: Does that also apply to chemotherapy.

MR. BROUGHTON: That is really a different story. The chemotherapy at the clinics is probably on the same basis, but we have another program for chemotherapy to patients who are being treated as private patients in their home and I think Dr. Cosbie had better explain that. This program is free to any patient whose doctor recommends them for the service. I think Dr. Cosbie could better describe that program.

DR. COSBIE: You see, in Ontario, in-patients get their drugs. We are very anxious to provide these therapeutic drugs. So we set up a plan in Ontario under which we have a control system providing free all these expensive drugs which are used in the treatment of cancer and we apply that to patients who are at home under the care of their family doctors.

We have three ideas in mind. First, we are tending to keep people out of hospital; two, we are tending to keep them in the home with their friends; and, three, we are helping the general practitioner who is looking after the patients by giving them the best drugs we can.

COMMISSIONER BALTZAN: One last question. The people who must undergo surgery; your Institute recommends that they go to their own surgeon?

DR. COSBIE: Yes.

COMMISSIONER BALTZAN: And have that surgery performed?

DR. COSBIE: Yes.





WILLIAM B. BARTON: I am that in

early in the morning

at 10:00 AM: That is really a

the history of the family

probably on the same basis, but we have another program  
for orthodontics to patients who are being treated as  
private patients in home care and I think Dr. Gordon  
can better explain that. This program is free to any  
patient whose doctor recommends them for the service.  
I think Dr. Gordon could better describe that program.  
Dr. Gordon: Yes, in Ontario, in-

patients get their drugs. We are very anxious to  
provide these therapeutic drugs. So we set up a plan  
in Ontario under which we have a central system providing  
free all these expensive drugs which are used in the  
treatment of cancer and we apply that to patients who  
are in need of cancer therapy.  
I have three areas in mind. First,  
we are trying to keep patients out of hospital.  
We are trying to keep them in the home with their  
family, where, we are helping the general public  
understand who is looking after the patient by giving  
them the best drugs we can.

Dr. Gordon: I am not sure that we have a  
very good understanding of the history of the family  
in Ontario. I am not sure that we have a  
very good understanding of the history of the family  
in Ontario. I am not sure that we have a  
very good understanding of the history of the family  
in Ontario.



Cosbie

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COMMISSIONER BALTZAN: And that is anywhere in Ontario?

DR. COSBIE: Yes.

COMMISSIONER BALTZAN: And lastly, in connection with this clinical research and the statistical follow-ups, how do you get the results, the findings, the outcome, in relation to these operative cases?

DR. COSBIE: It is an exceedingly difficult thing to do. Even if cancer is a registerable disease, there are big errors in it. We tried to find out the incidence of cancer in Ontario and we found it was highly inaccurate and we discontinued it. Then we went to the large general hospitals and asked them to organize tumor registries, and, as a result of our efforts, there are these tumor registries in a number of large hospitals, mostly around the university centres, today.

But when it comes to radiotherapy centres, there is no doubt about keeping a complete follow-up. I think you will notice in our brief that our figures run to 97% over 20 years of follow-ups. We are dealing with so many individuals and so many hospitals.

COMMISSIONER BALTZAN: I happened to be thinking of other places which provide so-called free treatment.

DR. COSBIE: No.

COMMISSIONER BALTZAN: Thank you.

COMMISSIONER GIRARD: Dr. Cosbie, I





Cosbie

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would like to ask you if you experience any difficulty in getting nurses to work in cancer hospitals?

DR. COSBIE: I will let Mr. Law answer that.

MR. LAW: As you know, there is difficulty in getting nurses, and we are now advertising in England, if this answers your question; but I think particularly you are interested in: does the nurse steer away from the cancer hospital? Is that your question?

COMMISSIONER GIRARD: Yes, that is one of them, and I have a reason for asking that question. Are there any special reasons why?

MR. LAW: I think all we have found is that nurses, as a whole, think that this is a dreadful thing to be involved in. We are now running an educational program and taking undergraduate nurses and giving them a very short period of training where they do realize these fears really do not exist to the extent they perhaps think they do.

COMMISSIONER GIRARD: You have almost answered the second question, and that question was: do nurses express the feeling they would like to have more experience in dealing with cancer patients? I ask that question because the nurses are having their annual meeting in Detroit, and I saw something in the paper and a lot of them deal with patients who had cobalt 60; most of these things dealing with the patient who had had cancer, and it seemed as though they were trying to give the nurses some additional information and I was







Law

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wondering if the nurses feel they are really handicapped in dealing with cancer patients who have had extensive surgery or radiotherapy?

MR. LAW: No, I would think not.

COMMISSIONER GIRARD: That wouldn't be one of the reasons?

MR. LAW: No.

COMMISSIONER STRACHAN: Mr. Chairman, in your summary, paragraph 9, you mentioned the importance of adequate training programs for radiotherapists, radiophysicists and radiotherapy technicians, and I take it you suggest a shortage of these personnel. Is this not an added argument in favour of your policy of centralization?

DR. COSBIE: Yes, absolutely. You can't develop Canadian radiotherapists unless you have institutes of this type. We have them in Saskatchewan, Manitoba, British Columbia, across the country, and we are very proud of the ones we have in Ontario and we always have a certain number of young men coming along and going into radiotherapy because they see its scientific application and they can see it develop to a very high level.

If you go back to the time when the radiotherapist was spending most of his time looking at pictures, that wouldn't interest radiotherapists at all. And it is rather interesting that this centre - they are even coming over from the United States to be taught in that centre. There are girls coming from the U.S.A. because they have nothing as good over there.



...in dealing with cancer patients who have had extensive surgery on a laboratory.

...I would think a lot of people would be interested in that country.

...one of the reasons.

...LAW: Yes.

In your summary, paragraph 9, you mentioned the importance of the training program for radiologists, radiophysicists and radiotherapy technicians, and a task at you suggest a shortage of these personnel. Is this not an added argument in favor of your policy of continuing this?

...Yes, absolutely. You

can't develop a national radiation program unless you have a sufficient number of this type of people. In fact, in the United States, Canada, Britain, Colombia, across the country, and in the very heart of the continent of Africa, there are always a certain number of people who are working along and going into radiation therapy because they see the scientific application and they can see it developing to a very high level.

...You go back to the time when the

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...it is rather interesting that this country

...they are even more interested in the United States to be

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So, we are training good radio technicians, and other scientists are working; we are getting good young men to come into physics, biophysics. But you have got to have everything to encourage them.

COMMISSIONER STRACHAN: In that connection, you have mentioned that British radiotherapists have immigrated to Canada. Does this apply to the radiophysicists and the radiotherapists?

DR. COSBIE: Yes, to a degree. But we can get more people trained as technicians and we can get more physicists coming in. We don't have to get as many of them from the United States. But the radiotherapists are in short supply. That is true across the country.

COMMISSIONER BALTZAN: Am I right that you are mainly emphasizing the centralization of radiotherapeutic teaching centre, not necessarily therapeutic centre?

DR. COSBIE: The two are so closely combined in that you can't dissociate them.

COMMISSIONER BALTZAN: I would like to see how it applies in a fairly large province.

DR. COSBIE: Look at the system we have with the Princess Margaret Hospital and these other centres, and they are pretty well separated on a geographic basis. Then we have developed consultative clinics and where the surgeons are interested in having a radiotherapist go out and discuss their problems with them.

I have seen this from a beginning and





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So, as an illustration of the fact that  
things, and other specialists are working, we are getting  
good things out of the fact that, in fact,  
you have got to have everything to encourage them.  
CONVICTS, I think, is that.

connection, you have mentioned that that is the  
and that is the reason for Canada. Does this apply to  
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the fact of the matter is that the relationship and the  
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CONVICTS, I think, is that



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I have seen it develop from the time where the radio-therapist is just doing a little radiotherapy on the side. Well, it has gone far from that today in the development of a centre where you have radiotherapists, radiophysicists and technicians. You can't have that in a small centre, you have to have a centre large enough to have a mass of patients where it is a rare thing that becomes, more or less, common and then you have a high standard of therapy.

COMMISSIONER BALTZAN: It may comfort you to know that I remember these things, too.

COMMISSIONER McCUTCHEON: You referred to therapeutic drugs being supplied to cancer patients being treated in their home by their family physician. The Foundation, as I understand it, passes out the drugs to any particular case, does it not?

DR. COSBIE: Yes, quite right.

COMMISSIONER McCUTCHEON: It is part, I suppose, of this educational procedure you were speaking of?

DR. COSBIE: Yes.

COMMISSIONER McCUTCHEON: Then the drugs are not supplied to every patient?

DR. COSBIE: As I may explain to you, when we set up this plan we brought out a form where, when a doctor has a patient under his care at home and he wants to write a prescription, he can turn to the back of the prescription form and he can see the drugs that we supply. We reserve the right to substitute, because when we originally set this up we asked the



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I have seen it develop from the time where the  
university is just doing a little radiotherapy on the  
side. Well, it has gone far from that today in the  
development of a cancer where you have radiotherapy,  
radiologists and technicians. You don't have the  
small centre, you have to have a centre large  
enough to have a mass of patients where it is a very  
big that becomes, more or less, common and then you  
have a high standard of therapy.

CONFIDENTIAL SOURCE: I am sorry

you know that I remember these things, too.

to these things being applied to a man, it seems  
being treated in their home by their family physician.  
The Foundation, as I understood it, passed out the  
things to any particular case, does it not?

CONFIDENTIAL SOURCE: Yes, quite right.

CONFIDENTIAL SOURCE: It is true.

I suppose, in this educational process, you were

concerned with

CONFIDENTIAL SOURCE: It is true.

things we had to do to every patient.

CONFIDENTIAL SOURCE: I am explaining to you.

when we had it to show we brought out a few more,  
and a doctor has a certain number of cases and then  
he wants to write a description, he can turn to the  
book on the proper order, form and he can see the  
way to apply. We wanted the right to education,  
and then we finally, at a time when we were



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3 doctor to use generic terms, to try to keep the cost  
4 down, because some drugs are frightfully expensive.  
5 So the doctor has to have the diagnosis substantiated  
6 by a clinic or a consultant, and when he completes the  
7 prescription, it has to go to one of the centres where  
8 we have a clinic.

9 Take the Princess Margaret Hospital.  
10 The prescription is checked by a chemist and then it is  
11 sent out and no charge is made for that drug and we  
12 trust the doctor to be a means test also because we  
13 wrote to them and told them if they are going to abuse  
14 this system they will not be supplied, and the remarkable  
15 thing is we haven't had one fault to find in a year-and-  
16 a-half; the doctors are co-operative on this thing; our  
17 bills are reasonable; we are getting an increasing number  
18 of patients, increasing number of doctors and we are  
19 perfectly satisfied the thing is working out very well.

20 We stamp it the second time that we  
21 reserve the right to substitute something else. We  
22 have never had to use it, and it is the only way to  
23 provide these things. There isn't enough money to  
24 supply these things.

25 COMMISSIONER BALTZAN: You take the  
26 doctor's assessment?

27 DR. COSBIE: We have always, and  
28 doctors never abuse it.

29 COMMISSIONER BALTZAN: Have doctors  
30 complained that they have had difficulty in obtaining  
them?

DR. COSBIE: No.







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THE CHAIRMAN: Thank you very much,  
Dr. Cosbie and your associates.

I think after these presentations,  
we are much better informed and we are grateful to you  
for taking the time.



THE LITTLE MAN. Thank you very much,

Dr. Joseph and your associates.

I think after these presentations,

we are in a better position and we are grateful to you

for taking the time.

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THE SECRETARY: The next submission will be the Canadian Council on Hospital Accreditation, which will be known as Exhibit 284. Their Appendix will be known as Exhibit 284A. Doctor Taylor will come forward and introduce his group.

S U B M I S S I O N O F  
THE CANADIAN COUNCIL ON HOSPITAL ACCREDITATION

---EXHIBIT NO. 284: Submission of the Canadian Council on Hospital Accreditation.

---EXHIBIT NO. 284A: Appendix to submission of the Canadian Council on Hospital Accreditation.

APPEARANCES:

MR. J.E. ROBINSON  
DR. EUGENE THIBAUT  
REVEREND SISTER M. JANET  
DR. B.H. McNEEL  
DR. W.K. WELSH  
DR. A.D. KELLY  
DR. W.I. TAYLOR

DR. TAYLOR: Mr. Chairman and Members of the Royal Commission on Health Services, Mr. Robinson the Chairman of Council will introduce the delegation supporting the submission to the Commission.

MR. ROBINSON: Mr. Chairman, before I begin, I would like to thank you for your warm reception of this Committee. The members of the group appearing are from my right, Dr. Kelly, General Secretary of the Canadian Hospital Association; Dr. Levinne, Vice Chairman





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THE SECRETARY: The next submission  
will be the Canadian Council on Hospital Accreditation,  
which will be known as Exhibit 18A. Their Appendix will  
be known as Exhibit 18A. Doctor Taylor will come forward  
and introduce his group.

SUBMISSION OF

Submission of the Canadian  
Council on Hospital Accreditation.

---EXHIBIT NO. 18A:

Appendix to submission of the  
Canadian Council on Hospital

---EXHIBIT NO. 18A:

REVEREND FATHER M. JAVIER  
MR. R.H. MCNEIL  
DR. W.I. TAYLOR

MR. TAYLOR: Mr. Chairman and Members

submitting the submission to the Commission.

MR. TAYLOR: Mr. Chairman, before I

begin, I would like to thank you for your warm reception of  
this Committee. The members of the group appearing are



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of Council; Dr. Welsh, a member of the Royal College;  
Dr. Thibault, a member of L'Association du Medicin de  
Langue Francais; Dr. Taylor, Executive Director and  
Secretary; Reverend Sister Janet from the Canadian  
Hospital Association and Dr. McNeel from the Canadian  
Association.

I am sorry that Dr. Chute and Dr.  
Piercey are not able to be present.

Mr. Chairman, I would like to briefly  
read our submission and leave the bulk of the time for  
questioning if that is your wish. Before I start, the  
submission is basically the work of our Executive Secre-  
try, Dr. Taylor, with some very able help from Dr.  
Kelly and Dr. Piercey.

#### S U M M A R Y

In our introductory presentation to  
the Royal Commission on Health Services at the Preliminary  
Hearing in Ottawa, we stated Council's conviction that

"because health is a provincial responsibility  
under the B.N.A. Act, the only way to compare  
the quality of hospital care among the  
provinces and assure an equitable standard of  
patient care in all hospitals, is by means  
of an organization such as the Canadian  
Council".

I might also add, sir, our submission  
is in both languages and all our activities are carried  
on in that fashion as well.

The narrative of our submission des-  
cribes how the Canadian accreditation program undertakes

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to do this, - how it carries forward activity to evaluate and compare the quality of hospital care being given and how it promotes activity to assure equitable standards of patient care in all Canadian hospitals.

In the same introductory presentation we said

"one of our chief concerns is to find the financial resources to assure the accreditation program's continuing independence, its national and bilingual character and its voluntary support."

This concern is reflected in our recommendations.

The narrative of our submission is in two parts. Part I describes the constitution, mode of operation and functions of the Canadian Council on Hospital Accreditation. Part II relates these factors to certain specific terms of reference of the Royal Commission inquiry, noting also some areas of your inquiry where we have no primary responsibility.

Our conclusions and recommendations are deduced from the discussion chronicled in the various sections of the narrative. They are reiterated in this summary to preface the narrative of the submission.

#### Conclusions

Our conclusions, which derive from relating the facts and circumstances detailed in the narrative to the specific terms of reference of Order in Council 1961-883, are as follows:

#### Existing Facilities





1968 Robinson

to do it, - how it carries forward activity to evaluate  
and compare the quality of hospital care being given and  
how it promotes activity to assure equitable standards  
of patient care in all Canadian hospitals.  
in the same introductory presentation

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specific terms of reference of the Royal Commission  
inquiry, noting also some areas of your inquiry where we  
have no primary responsibility.

deduced from the discussion included in the various sec-  
tions of the narrative. These are referred to in this  
summary to provide the narrative of the submission.

reaching the facts and circumstances outlined in the  
narrative to the specific terms of reference of your in-

quiry 1964-65, are as follows:

Relevant Facts



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(a) The Canadian Council on Hospital Accreditation is not concerned with provision of facilities as appropriate to any hospital or to any hospital region, that is to say, Council is not concerned with regional hospital planning. Council is concerned that the existing facilities in an accredited hospital meet the accreditation standards especially those for patient safety and for diagnostic and treatment services suitable to the training and competence of those who will use those facilities.

Improving Existing Services

(b) The Canadian hospital accreditation program improves existing hospital services by assuring safer hospital buildings and adequate facilities for hospital services; by encouraging the board of governors of a hospital to assume legal and moral responsibility for the quality of patient care rendered in the institution; by seeing to the organization of the medical staff of a hospital so that the physicians on the staff can properly assume their dual responsibility, that is, their responsibility for quality medical care of all patients and for proper professional practices by all staff members; and by insisting that in the accredited hospital there is professional nursing service available for all patients at all times.

Extending Existing Services



The Canadian Council on Hospital Administration  
has not been given the provision of facilities  
as appropriate to any hospital or to any  
hospital region, nor is to say, Council is  
not concerned with regional hospital planning.  
Council is concerned that the existing facto-  
ries in an economic hospital fact the  
a creditable standard especially those for  
patient care and for diagnosis and treatment  
services available to the training of a compe-  
tent of those who will use these facilities.

General Hospital Administration  
The Council on Hospital Administration should  
improve existing hospital services by assur-  
ing better hospital administration and management  
which leads for hospital services; by encourag-  
ing a better of services of a hospital to  
the public and to hospital management for the  
improvement of patient care and management in the  
hospital and by leading to the improvement of  
the medical staff of the hospital and by  
improving the hospital management in general.

The Council on Hospital Administration should  
improve the hospital management and by assur-  
ing a better of services of a hospital to  
the public and to hospital management for the  
improvement of patient care and management in the  
hospital and by leading to the improvement of  
the medical staff of the hospital and by  
improving the hospital management in general.



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(c) Council is aware of the need to extend the accreditation program to more small general hospitals and to other types of patient care institutions and is planning and working toward a more comprehensive program adapted to the needs of these institutions. Council also recognizes and collaborates with other organizations whose activities could aid or complement the work of the accreditation program to improve quality of patient care in Canadian hospitals.

#### Present and Future Needs

(d) The accreditation program urges hospitals to make use of the best qualified personnel resources available to them and points to areas where there are deficiencies of personnel in numbers or in qualifications as measured by the standards of the accreditation program. It encourages hospitals to remedy these deficiencies where this is possible by the use of part time consultant services from the larger community. The program, therefore, is helpful in encouraging the most economical use of the professional and technical personnel resources available for patient care in the community served by the accredited hospital.

#### Adequacy of Personnel

(e) The Canadian Council on Hospital Accreditation has an indirect but real interest in the education and training of the people needed





...of the need to extend the  
...to more small business  
...of patient care  
...in planning and working  
...a more comprehensive program  
...the needs of these institutions  
...and coordinated with other organi-  
...and the need for a complete  
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for modern hospital care, for present needs and for the future, and collaborates with the Royal College of Physicians and Surgeons of Canada and with the Canadian Medical Association, by assessing training programs in hospitals for specialists, junior interns and technologists.

#### Future Requirements

(f) Council is not concerned with planning in the health field in general terms, but the findings on survey of hospitals which result in recommendations to hospitals, may prove to be of value to organizations responsible for general planning.

#### Methods of Financing

(h) The major source of revenue for support of the Canadian accreditation program has been from the voluntary contributions of the Members of Council. Council is convinced that any method of securing additional monies needed to finance the program must ensure that the independent and voluntary character of the program is not jeopardized by the manner in which such financial aid is given or received.

#### Future Financing

(i) The method of financing any future extension of the accreditation program should adhere to the existing principles of obtaining revenue or such modification of them as will not compromise the independent and voluntary character of the accreditation program.





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Synopsis of Conclusions

In synopsis of the stated conclusions, we have shown that the Canadian Council on Hospital Accreditation is operating a survey and accreditation program to promote and maintain quality health care in Canadian hospitals. The program is independent, voluntary, national and bilingual. It has had successful acceptance by Canadian hospitals and has proven itself capable of performing a function which is in the public interest. Assuring its continuity in its independent and voluntary form is of concern to Council and of importance to the public health.

THE CHAIRMAN: Thank you. In connection with methods of financing, both present and future, may we take it as correct that you are satisfied with your present method, that that method does give you the independence that you want?

MR. ROBINSON: We believe it does, sir, insofar as more than half of our resources are provided through our member organizations, and substantially less from Government sources. We are not satisfied in that the amounts available are not adequate to expand the program to any great extent, and our member organizations are unable at the present time to increase their portion of the contribution.







THE CHAIRMAN: Well, this contribution that the member makes, is that recognized as an operating expense of the member hospital by the hospitalization plan?

MR. ROBINSON: Yes sir it is. It is part of the amount that the local hospital pays to their provincial hospital association, and then the province is assessed a certain amount by the Canadian Hospital Association, and pays \$4,000.00 a seat for the seats on Council.

THE CHAIRMAN: Is there any difficulty in having that amount, whatever it might be, recognized as an operating expense?

MR. ROBINSON: Not insofar as the hospitals are concerned so far, sir, but the medical members have to find their resources out of their individual pockets, and this makes it a substantially greater problem for them than for the hospital members.

THE CHAIRMAN: The medical members, what do you mean by get their resources out of their own pockets? Do they serve as volunteers?

MR. ROBINSON: Well, you see there are for instance five hospital members on the Council. Four from the Canadian Medical Association; two from the Royal College of Physicians and Surgeons. Their payments come from their assessment of the members of those Associations.

THE CHAIRMAN: Of their own assessment?

MR. ROBINSON: Right sir.

THE CHAIRMAN: So that the individual





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TORONTO, ONTARIO

Robinson

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member is not a volunteer in that sense?

MR. ROBINSON: No, I think we consider ourselves all volunteers in that we do this activity without reimbursement.

DR. KELLY: To illustrate where the money comes from in respect of the Canadian Medical Association, we contribute from the resources of the C.M.A. \$16,000.00 a year to this worthy cause, and have done so for 12 years. Now, our resources are not unlimited, and although we are sympathetic to the needs of the Council, we would find it pinching us a little bit to raise that \$20,000.00.

THE CHAIRMAN: And the Royal College?

DR. WELSH: They are in the same position sir.

DR. THIBAUT: Is there any objection if we say the amount that each member pays? We are 12 members through five of the Canadian Hospital Association, two of the Canadian Medical Association, two of the College, and one of the L'Association du Medecin de Langue Francais du Canada. Those are all organizations, which makes 12 members, and each member has to pay \$4,000.00 for a seat.

THE CHAIRMAN: I know what the Constitution says, because I think at one stage or another I was asked to pass upon it. Is it necessary, I mean do you see it necessary that the contribution of all 12 of these professional representatives, I am talking now from the Medical Association and so forth, would necessarily have to contribute the same amount as





...is not a volunteer in the sense?

...all volunteers in that we do this ...

Dr. Williams: In this state where the

...in respect of the Canadian Medical

Association, we contribute from the resources of the

C.M.A. \$2,000.00 a year to this worthy cause, and

have come so far in regard to how our resources are not

utilized, and although we are sympathetic to the needs

of the Council, we would find it preferable to a little

not to raise that \$2,000.00

Dr. Williams: And the Royal College?

Dr. Williams: They are in the same

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has to pay \$1,000.00 for a year

Dr. Williams: I know what the

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of all of these professional organizations is

...now from the Royal Association and so forth,

...have to contribute the same amount as



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3 the hospital representatives?

4 DR. TAYLOR: Mr. Chairman, this is  
5 an aspect of financing which presently is being looked  
6 at. Dr. Piercey ---

7 THE CHAIRMAN: You see, that is the  
8 aspect that we are concerned with. I am not saying that  
9 we are unmindful of obligations that the Canadian  
10 Medical Association or the Association du Medecin de  
11 Langue Francais -- they may spend what they like. It  
12 is not part of our concern, but in terms of hospital  
13 operation and the use of the 50-50 contribution of  
14 Dominion and Province in terms of where that money goes,  
15 is naturally within the scope of our enquiry.

16 DR. TAYLOR: This is a question, Mr.  
17 Chairman, which was discussed at a recent meeting of  
18 Council in January. Dr. Piercey proposed to take this  
19 question back to his Association for their Board of  
20 Directors.

21 THE CHAIRMAN: That is the Hospital  
22 Association?

23 DR. TAYLOR: Yes, that is the Hospital  
24 Association. For their consideration this year as to  
25 whether there might be some means whereby that Associa-  
26 tion, the Canadian Hospital Association, could contribute  
27 a greater amount to the work of Council. This would  
28 have certain implications, however, in Council itself  
29 if as a result of the greater contribution the Canadian  
30 Hospital Association were to ask for another seat for  
example. Because the balance of seats we think is very  
good at the moment to assure no undue influence by any

the Hospital representatives

an aspect of financing which presently is being looked

at. Mr. Bishop --

THE CHAIRMAN: You see, that is the

aspect that we are concerned with. I am not saying that

we are ungrateful of obligations that the Canadian

Medical Association or the Association in Medicine do

have towards us -- they may spend what they like. It

is not part of our concern, but in terms of hospital

operation and the use of the 25-50 contribution of

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question back to his Association for their board of

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good at the present to allow no more influence by any





Robinson

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4 member. The independence of which we are so cognizant  
5 in the Canadian Accreditation program extends within  
6 Council itself, so that there can be no question at any  
7 time of any institutional or organizational influence  
8 which might upset the balance of Council.

9 THE CHAIRMAN: Do you sense any greater  
10 value in this accreditation proposition to the hospitals  
11 vis a vis the doctors? In whose interests is it best  
12 that this program should go forward?

13 MR. ROBINSON: I think in that sense ---

14 THE CHAIRMAN: It is the hospitals?

15 MR. ROBINSON: Yes.

16 THE CHAIRMAN: And provided you do not  
17 run into any difficulties of having government, either  
18 provincial or federal, deny you the right to appropriate  
19 some of the operating expense towards it, then you will  
20 have no problem, is that right?

21 MR. ROBINSON: I would hope so. This  
22 balance is a very delicate one.

23 THE CHAIRMAN: No, this balance is  
24 something else. I am talking about money only.

25 MR. ROBINSON: Money only we would  
26 have no problem.

27 DR. TAYLOR: We had a very nice  
28 reception from the Minister of National Health and  
29 Welfare in Ottawa when we made our report this March.  
30 We would have expectations that the government would  
again support the requests that we have made, and if  
they do, and if the program is not altered greatly,  
but has normal expansion in the next three years, we





...of which we are so concerned  
in the Canadian Accreditation Council's work. I think  
Council itself, so that there can be no question at any  
time of any institutional or organizational in issues  
which might upset the balance of Council.

THE CHAIRMAN: Do you agree any more  
with this accreditation proposition to the hospital  
view to the contrary? In whose interests is it that  
there is no longer should be towards?

MR. ROBINSON: I think in that case  
THE CHAIRMAN: It is the hospital?

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MR. ROBINSON: I would have so. This  
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THE CHAIRMAN: No, this balance is  
something else. I am talking about money only.

MR. ROBINSON: There is only a small  
amount involved.

MR. ROBINSON: It had a very nice  
report from the Council of National Health and  
Welfare in Ottawa, when we made our report this year.  
It would have expected that the government would  
main support the hospitals that we have here, and in  
fact, but it is obvious in the other way,  
it has normal situation in the next three years, or



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foresee no great difficulty in financing up to '65 or '66.

THE CHAIRMAN: Because it would appear to be in the interests of the Departments of Health, both at provincial and federal level, to have the best type of hospital, the best accredited hospital is going to be the most efficient and so forth and et cetera?

DR. KELLY: There is one feature of financing which has not been spelled out in this little discussion. For the past two years we have enjoyed a contribution totalling \$30,000.00 from a small slice of the general public health grant. The federal government, with the consent of the provinces, give a very, very small percentage of that large national health grant to this program, and we are very appreciative of that.

THE CHAIRMAN: Now, as the number of hospitals increase, I suppose the expense of the accreditation program will pyramid in that sense?

MR. ROBINSON: That is right. One further comment, and that is that this contribution from the federal government is given only with the consent of the provinces, and one province has not yet given us their share of the amount. This is a bit of a problem.

THE CHAIRMAN: This is perhaps a very narrow phase, but in paragraph b on page 2 of the summary:

"The Canadian hospital accreditation

"program improves existing hospital

: УЧЕНИЦИ





Robinson

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"services", et cetera, "---by encouraging  
"the Board of Governors of a hospital  
"to assume legal and moral responsibility  
"for the quality of patient care ---".

It does not quite ring a bell with me. How can a program  
impose any legal responsibility? I mean, a legislature,  
a parliament?

DR. TAYLOR: I think that is correct,  
Mr. Chairman, but -- in fact it is correct -- but I  
think in the past it has been the experience of any  
hospital boards across Canada that their prime  
responsibility was to somehow or other find some money  
to keep the institution open. The general history of  
hospitals has been that until the advent of hospital  
insurance there was a great scramble all through the  
year to get enough money to keep the doors open, and  
a further scramble at the end of the year to try to  
cover a deficit.

The financial matters affecting a  
hospital operation almost exclusively seem to be in the  
thought of responsibility of many hospital board members.  
I think that this thought was not disturbed greatly  
by some members of the medical profession too, who felt,  
okay, running the hospital is your business, but  
patient care is ours, so that to many people trustee  
responsibility for patient care is a comparatively new  
thought.

THE CHAIRMAN: Well, it has been a  
developing matter in jurisprudence from the old day  
when the surgeon in the operating theatre was lord and





"nervous", et cetera, "---in connection  
"the Board of Governors of a hospital  
"to assume legal and moral responsibility  
"for the quality of patient care ---".

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by some members of the medical profession too, who felt,  
"well, running the hospital is your business, but  
patient care is ours, so that to many people there  
responsibility for patient care is a comparatively new  
concept."

THE CHAIRMAN: Well, it has been a  
developing matter in this regard from the old day  
when the person in the operating theatre was lord and



Robinson

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master of all creation within the walls.

DR. TAYLOR: We are very happy to report that as the result of education, I think very considerably as the result of education put forward by our program, board members are becoming more and more cognizant of their responsibility for the quality of medical care in the hospitals they operate.

COMMISSIONER FIRESTONE: Mr. Robinson, if we can refer to paragraphs 46 on page 13 and paragraph 47 on page 14. You say in paragraph 46 that:

"In the United States the demand for  
"accreditation service has gone one  
"step farther",

and there is a demand for joint accreditation services to include:

"--in-patient care institutions 'other  
"than hospital' i.e. nursing homes".

Then in paragraph 47:

"The Canadian Council on Hospital  
"Accreditation has had no formal  
"representation made to it on behalf  
"of nursing homes but we know their  
"identification and classification  
"has presented problems to certain  
"hospital insurance commissions".

Does your Association feel that you could perform a useful function to provide a system of accreditation of in-patient care institutions?

MR. ROBINSON: Yes sir we do.

COMMISSIONER FIRESTONE: Would you





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4 accept such a responsibility if you were asked to do  
5 so?

6 MR. ROBINSON: As soon as we were  
7 able to do so financially and personnel-wise, yes.

8 THE CHAIRMAN: Provided that the means  
9 were made available at the same time as the request?

10 MR. ROBINSON: Yes.

11 COMMISSIONER FIRESTONE: Who would  
12 have to ask you to accept this additional responsibility  
13 before you could do so?

14 MR. ROBINSON: Well sir, we are a  
15 voluntary -- no one has to accept our services. Presumably  
16 the nursing homes would request it. There have been  
17 some tentative enquiries in this regard from the better  
18 nursing homes already.

19 COMMISSIONER FIRESTONE: You mentioned  
20 that the problems that are being faced ---

21 THE CHAIRMAN: I would think that  
22 the province would have the power to license and to  
23 inspect and to delegate by whom the inspection could  
24 be made.

25 COMMISSIONER FIRESTONE: In paragraph  
26 47:

27 "--- problems to certain hospital  
28 "insurance commissions".

29 Presumably if you were asked by such commissions or the  
30 appropriate provincial government department as the  
Chairman mentioned, you would undertake such functions?







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MR. ROBINSON: That is right, sir.

We feel that our responsibility really is to provide a watchdog on patient care and certainly on all patient care in general hospitals at the moment.

COMMISSIONER FIRESTONE: As you appreciate there have been suggestions made that there is a great deal of need in Canada to create additional institutional facilities to take care of patients and get them out of the general hospitals, so one can see the problem is going to become more complex and unless there are watchdogs that will assure such facilities we would not be assured of the high quality of facilities that you were starting to achieve at the hospital level. One more question, when we speak of in-patient care, institutions other than hospitals, what other institutions do you have in mind besides nursing homes?

MR. ROBINSON: I would think of rehabilitation hospitals, long-term hospitals, geriatric hospitals or institutions is a better word, I guess. The whole gamut of in-bed patient care. Mental is another area, but we will look towards providing the best for a mental hospital survey program.

COMMISSIONER FIRESTONE: What are you doing in that field of mental hospitals at the moment?

DR. McNEEL: Mr. Chairman, for the last two years a committee of the Canadian Psychiatric Association and a committee of this Council have been working on standards for mental hospitals. We now do not have any final plan, but we plan to make a trial run in about half a dozen mental hospitals to try out the standards,



... in English. That is right, sir.

We see that the responsibility really is to provide a  
standard on which to base our action on all points.

There is general agreement at the moment.

... in English. That is right, sir.

But there have been suggestions made that there is a great  
need of some standard to create stability in the international

activities to have care of patients and get them out of

the general hospital, so one can see the picture is

going to become more and more and there are some

ways that we have some facilities we will not be

aware of the right kind of facilities that you want

... in English. That is right, sir.

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McNeel 10375

to modify them, to set up a survey and report forms and things of this sort. We are really hoping to do something of this sort this Summer.

COMMISSIONER FIRESTONE: And you have initiated that program at whose request?

DR. McNEEL: It was a joint effort of the Canadian Psychiatric Association and the Council.

DR. TAYLOR: I should say it was partly because we were in an embarrassing situation because of the United States, the Joint Commission on Accreditation of Hospitals had been surveying mental hospitals. Our Council, when we became incorporated and started operations in 1949, would not accept that the standards as retained generally for general hospitals were applicable to mental hospitals. We specifically asked Dr. McNeel and some other people whether this position was justified and they agreed with us that if we were to embark on surveying mental hospitals that there should be an extension of the standards in terms more directly applicable to care of psychiatric patients. In part, you see, we were already obligated, we felt, to serve in these hospitals because some of them in Canada had been, in fact approved by the Joint Commission and are no longer approved. They won't be accredited, they won't be recognized as having good patient care. We have had nothing as yet in appropriate yardsticks to measure their performance in order to grant them a Canadian certificate.

THE CHAIRMAN: When you say no longer it is because the American association withdrew, was it not?







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DR. TAYLOR: That is right.

THE CHAIRMAN: And you have not yet filled up the void?

DR. TAYLOR: That is right.

COMMISSIONER FIRESTONE: I take it what you have said such as in the case of mental hospitals you have proceeded with such examinations and the setup of standards and a pilot project, as you explained, without waiting for a request from the Provincial Government. Am I correct?

DR. TAYLOR: That is right.

COMMISSIONER FIRESTONE: I am wondering if you have shown such initiative and imagination in this field why this could not be done in some other areas. I am thinking of institutions for the chronically ill?

DR. TAYLOR: We are in the process of adopting further our standards of hospitals for chronic care. We already have some hospitals accredited which can meet them by the existing standards, no very great modification is needed. As a matter of fact, it is in the interpretation of existing standards it is needed.

COMMISSIONER FIRESTONE: Would you say that if the Federal grant which is about \$30,000.00, subject to that one little qualification you added, was raised to \$50,000.00 you could carry on more of this type of work and do studies in other areas in which you are not at the moment?

DR. TAYLOR: Indubitably.

COMMISSIONER FIRESTONE: Would you



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Taylor 10377

consider this a desirable operation or function?

DR. TAYLOR: We would.

COMMISSIONER FIRESTONE: I was going to ask you what you mean in Paragraph 4 of your summary when you speak of suggesting that this Commission endorse the continuity of your program and, I quote, "Any future extension of it". Do I take it that future extension means you are visualizing not only doing more of the same sort of program you are doing now, but also branching out into new areas, is that what you mean?

DR. TAYLOR: By future expansion we mean getting more small hospitals into the accreditation program. Secondly, if and when going into a survey on accreditation hospitals, after that, what the future may bring forth -- someone may ask us someday would we be willing to go into the field of nursing care and if this is patient care within the terms of reference as thought of by Council at the time such request is made, then I think this could be that is on the periphery of our extending activity.

COMMISSIONER FIRESTONE: Have you any specific recommendations as to increasing the Federal grant which you are now receiving under this arrangement of the order of \$30,000.00 to an additional amount for the future extension of your activities?

MR. ROBINSON: Dr. Taylor mentioned we asked the Federal Minister of Public Health and Welfare in March for an additional \$10,000.00 over the next two years which will permit us to extend our existing program. However, we have estimated that to do that plus the





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hospitals would take an additional \$15,000.00 above that at least, and it may take more. This is our estimate based on very little information at the moment.

COMMISSIONER FIRESTONE: So your request for a contribution would be for \$55,000.00? That is, \$30,000.00 now plus \$10,000.00 plus \$15,000.00, is that correct?

MR. ROBINSON: That is correct. There are some genuine worries on the part of Council about this, because it takes it above the matching 50% mark. We have always hoped we could find at least half our resources from non-governmental sources. My own view is that this cannot be done forever some other method will have to be found. I think we will be satisfied providing there is some way found to do it that did not prejudice our capacity to remain independent.

COMMISSIONER FIRESTONE: Would you feel that making available to you the sum of \$55,000.00 under the Federal grant system without any strings attached would in any way interfere with the operation of your program?

MR. ROBINSON: There has been no evidence of this yet.

COMMISSIONER FIRESTONE: Have you any fear as to the future?

MR. ROBINSON: There have been fears expressed by members of Council.

COMMISSIONER FIRESTONE: Have you any evidence to substantiate such fears?

MR. ROBINSON: None at all. There was



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one instance where the Province asked that their member of their standards committee be permitted to go with our surveyor to survey the hospitals and we refused this request; there we have had no further requests of that sort.

COMMISSIONER FIRESTONE: Has there been any interference from the Federal Government?

MR. ROBINSON: None at all, no.

COMMISSIONER McCUTCHEON: The Federal Government would pay out the money to the Province in any event?

THE CHAIRMAN: Half.

COMMISSIONER McCUTCHEON: I thought it was the whole thing.

DR. KELLY: That is part of the general public health grant, it is not a matching grant to the Province, if they send their total receipts for that year our rates are up a very small amount.

COMMISSIONER McCUTCHEON: So it is really the Province and I take it what your concern is that as and when the Governments are providing the bulk of your money there is a tendency in other areas there has been up to date, of Governments taking more direct interest in how the money is spent, in fact, they will be paying you to increase their budget for hospital care?

MR. ROBINSON: That is exactly right. Just to give you an example, a small hospital in rural Saskatchewan was surveyed by one of our surveyors who made certain recommendations with regard to the plant to





MEMORANDUM

TO: THE SECRETARY OF THE INTERIOR

of their standards committee be permitted to go with our  
conveyance to survey the forests and we released this  
request, since we have had to contact a series of land  
owners.

On October 17, 1941, the Secretary has been

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bring it up to a decent level of operating efficiency. It was discovered later when the people went to ask for the funds to do it that to the Provincial Government this was a hospital that they had planned to eliminate in their total system of hospitals.

DR. THIBAUT: Ou aime bien aussi que l'autonomie des Provinces soient respectée.

We do ask that the autonomy of our province be respected.

COMMISSIONER BALTZAN: You only make a survey of any hospital that invites a survey or asks for an examination, you do not go to a hospital on your own?

MR. ROBINSON: No, sir.

COMMISSIONER BALTZAN: And the number of hospitals over and above fifty beds, what percentage have had this survey? I was trying to find out in your statistics, I see a list of the hospitals ----

DR. TAYLOR: I am sorry, I cannot give that specifically from fifty to one hundred beds. There are only about 17% of the hospitals -- 16% of the hospitals twenty-five to fifty beds are accredited. The percentage above from fifty-one to one hundred beds is much better than the twenty-five to fifty, we know that, but there are still quite a number of hospitals under one hundred beds which should be in the program and which are not.

COMMISSIONER BALTZAN: What is your special problem in relation to the under one hundreds and the twenty-five to fifty group?



THE SECRETARY OF THE  
TREASURY  
WASHINGTON, D. C.

TO THE HONORABLE THE SECRETARY OF THE  
TREASURY

DEAR SIR:  
I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours, very truly,  
J. M. [Signature]

Enclosed for you are two copies of the report of the Committee on the subject of the proposed amendment to the Internal Revenue Act of 1913.

I am, Sir, very respectfully,  
Yours, very truly,  
J. M. [Signature]

I am, Sir, very respectfully,  
Yours, very truly,  
J. M. [Signature]



Taylor

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DR. TAYLOR: It requires some considerable thought and adjustment of our standards by these smaller hospitals to make them applicable. We are quite sure that the reason many hospitals are not in the program - they pick up the set of standards, they see the whole organization, a set of committees and they say: "My goodness, we can't do that." But it is not organizational form but functions, and these can be performed by as few as three medical staff members.

This is explained to the hospital and if they can do it in terms of their operation then they can meet the standards. This can't be done on paper, it can be done on visiting the hospital.

COMMISSIONER BALTZAN: You can be very helpful to these hospitals.

DR. TAYLOR: We would be very happy to do more business than we have been able to do.

COMMISSIONER BALTZAN: Would it be helpful if you could have accreditation applied to all those who could meet these standards, if you introduced another term?

In other words, that you have made the inspection and due consideration given to their limitations and according to their circumstances they are performing suitably.

DR. TAYLOR: Mr. Chairman, we would not like to have two standards. We think there is one standard for minimum patient care. We think, in the small hospital, they can give just as good care as they







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can in the large metropolitan centre providing they give that care which is within the areas of their capacity and do not attempt things which are beyond the services or competency of the people that are there.

COMMISSIONER BALTZAN: I hope you understand it will - I don't mean to imply second-class hospitals. The small hospital of 50 beds can be a first-class hospital in the manner in which they perform, etc., still be a first-class hospital and yet not have all this departmentalization as a 200 and 400-bed hospital.

DR. TAYLOR: Yes, and it gets the stamp of approval just the same as the largest hospital, as St. Michael's, if I may say so. It is a standard of patient care.

MR. ROBINSON: We have written an interpretation of standards for small hospitals which I think has been of considerable help to them in interpreting the standards to their local situation. But I agree with you, that there is a lot still to be done in this direction, and it is harder for a 25-bed hospital to be accredited than a 500-bed hospital.

COMMISSIONER GIRARD: Dr. Taylor, I would like to help you uphold this laudable objective of presenting your brief in this form by asking my questions in French, but unfortunately the Court Reporter will not be able to take that.

Have you ever considered getting a little bit more money by offering a seat to the nurses' association?





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DR. TAYLOR: As far as we are concerned, they have not made application for a seat. This is an area, I think, which is open to decisions which may be made in the future. Certain professional organizations have made enquiries; one or two have, at least, made overtures. There are certain organizations which we think might well be represented on council and they have made no request.

Perhaps in this area there is part of the answer to our question of voluntary contributions from associations which will always keep our finances in good balance.

COMMISSIONER GIRARD: I don't know really if the Canadian Nurses' Association would want to be on it. I really don't want to talk for them. But you did say a little later on that the seats were pretty well balanced, so that gave me the impression that another seat for the Canadian Nurses' Association would be an imbalance.

THE CHAIRMAN: A deciding vote, maybe.

DR. TAYLOR: Our only concern is that no member of council should be able to forward member interest rather than patient interest as represented by the balance of seats.

COMMISSIONER GIRARD: I think the Canadian Nurses' Association have a long-standing reputation for forwarding the interest of patients. But, of course, I repeat again, I am not talking for the Canadian Nurses' Association.

There was something else you said, Dr.







Taylor

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Taylor, in reply to Dr. Firestone's question; in the extension of your program in the future, one of the ways of extension may be going into the realm of patient care. Would you like to expand this to see how far this would go?

DR. TAYLOR: So far it has been a hospital accreditation program and one must define a hospital somehow. For our purposes only a hospital eligible for accreditation is a hospital which has 25 beds or more. Now, we think there are some institutions which have more than 25 beds which are not, in fact, hospitals; that is, they don't give all the types of services which is expected a hospital would give.

We are quite sure there are some institutions which have fewer than 25 beds which are, in fact, hospitals, but we must draw the line some place.

Now, what type of care is going to be given? If it is essentially custodial care, then we are not interested. The classification of these institutions would somehow have to be undertaken. If the essential thing done there is medical care, then that type of institution may be eligible for accreditation.

COMMISSIONER GIRARD: One more question which pertains to finance, and this is not my field, but I would like to have the answer to this.

How would you assess the hospital for payment when you visit the hospital for purposes of accreditation? You do get some payment from the hospital?

DR. TAYLOR: No, it is a free service.





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COMMISSIONER GIRARD: I thought there was something from the hospital for the expenses of that person visiting the hospital.

DR. TAYLOR: Only the Association fee is paid to the Provincial Hospital Association and it goes to the Canadian Hospital Association and is used for buying seats on council.

COMMISSIONER GIRARD: I thought I read something that they have to pay something to belong to an association and it is based on the number of beds. It is just a matter of opinion, but it may be you get less there.

DR. TAYLOR: The question has come up whether a direct assessment should be made as part of the cost of the survey, and it has been rejected, because we don't want the hospitals to feel they can buy this service. If they pay their money, then they want something to show for their money, they want a certificate on the wall. I think this puts undue pressure on our council and on our people.

In order to be completely impartial, we feel it is better if the money does not come direct.

COMMISSIONER GIRARD: Where it is done - and I am thinking now particularly of the accreditation of nursing services in the United States - they pay a certain amount and they don't feel they are paying for accreditation; they feel it is for someone going into council. They don't feel they are paying for accreditation, they are paying for a consultation service.

THE CHAIRMAN: You were an offspring of







Sister Janet

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the American association. They did accreditation here for years and you accepted what you thought was good in their plan and you rejected what you thought was not good. Whether Miss Girard can convince you you are wrong, I don't know.

SISTER JANET: I would like to say, Mr. Chairman, that indirectly we are paying for consultation in paying our provincial fees, and if they feel they need more money, then the fees go up. But it is not a direct cost for accreditation.

DR. LEVINNE: Whether they are making contribution or not, in an indirect sense they are still eligible for accreditation. They are eligible for accreditation even though they don't make any contribution to the provincial association.

THE CHAIRMAN: Thank you very much, Mr. Robinson.

#### SUMMARY

##### Recommendations

The Canadian Council on Hospital Accreditation recommends to the Royal Commission on Health Services, that the Royal Commission on Health Services

1. ACKNOWLEDGE that the Canadian Council on Hospital Accreditation is operating successfully an independent and voluntary program for health care in Canadian hospitals on a national and bilingual basis and that continuance of this program is in the public interest.

2. EXPRESS to the government of Canada





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4 and the governments of the provinces of Canada, our  
5 appreciation for the financial support granted to this  
6 voluntary organization in the past two years, without  
7 which it would not have been possible to carry on the  
8 work of Council at the described level of activity.

9 3. INFORM those bodies of government  
10 that the use of public health grant funds is, in general,  
11 a satisfactory method of supporting the Canadian Council  
12 on Hospital Accreditation since there is no evidence  
13 that this method compromises the independent and volun-  
14 tary character of the program.

15 4. COMMEND the program operated by  
16 the Canadian Council on Hospital Accreditation to the  
17 government of Canada and the governments of the provinces  
18 of Canada, asking for their continued moral and financial  
19 support and that this continued support be maintained  
20 at such a level as will assure continuity of the program  
21 and any future extension of it which is in the public  
22 interest and within the resources of Council.  
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THE SECRETARY: Next, sir, we have the Faculty of Household Science, University of Toronto, and Dr. McLaren will present this brief and it will be known as Exhibit 285.

--- EXHIBIT NO. 285: Submission of the Faculty of Household Science, University of Toronto.

SUBMISSION OF THE FACULTY OF HOUSEHOLD SCIENCE,  
UNIVERSITY OF TORONTO

Appearance: Dr. B.A. McLaren

MISS McLAREN: Mr. Chairman, the information included in this report is concerned with the education of Household Science graduates and the areas in the community in which they are employed.

Suggestions are limited to ways and means of improving the health of Canadians from the standpoint of the role of nutrition and management in the prevention and treatment of disease and subsequent rehabilitation.

Recommendations are directed towards improving the health of Canadians through more effective utilization of the existing educational facilities, in accordance with the stated purpose of Order in Council P.C. 1961-883.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

R.1 Need for Recruitment of Household Science Students

- (a) The present shortage of teachers and dietitians is acute. (Para. 24)
- (b) The limited number of Household

THE SECRETARY: Next, sir, we have the  
Faculty of Household Science, University of Toronto,  
and Dr. Wilson will present this brief and it will be  
followed by Dr. Wilson.

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Household Science, University  
of Toronto.

MISS McLELLAN: Mr. Chairman, the infor-  
mation included in this report is concerned with the  
education of household science graduates and the areas  
in the community in which they are employed.  
Suggestions are limited to ways and

means of improving the health of Canadians from the  
standpoint of the role of nutrition and management in  
the prevention and treatment of disease and subsequent

Recommendations are directed towards  
improving the health of Canadians through more effective  
utilization of the existing nutritional facilities, in  
accordance with the stated purpose of the Council.

#### RECOMMENDATIONS AND RECOMMENDATIONS

1. Need for Re-evaluation of Household Science Curriculum

- (a) The present shortage of teachers  
and dietitians is acute. (Para. 24)
- (b) The high cost of household



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Science graduates in Ontario does not meet the increasing requirements for hospital and school expansion.

(Para. 25)

(c) The development of the integrated internship program in hospitals has increased the interest of High School students in Household Science.

(Para. 26)

(d) Admission and in-course scholarships would further increase recruitment and the government is requested to consider providing financial support.

(Paras. 27, 28)

R.2 Need for Re-organization in the Training of Auxiliary Personnel

(a) Students could be trained for positions in food service, management, hygiene and sanitation in the existing trade, technical, vocational schools and institutes. (Paras. 29-31)

(b) These trained employees could improve their status by evening extension classes and experience.

(Para. 32)

R.3 Need for "Specialist" in the Present School System in the Areas of Nutrition, Management and Family Relations

(a) The teenager is an important member of our society and is subjected



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to great physiological and emotional stress. (Para. 33)

(b) It is recommended that special attention be paid to this group in the public and junior high schools. (Para. 34)

R.4 Need for Consultants Trained in Household Science on the Staff of Welfare Agencies

(a) Nutrition and management are necessary in the rehabilitation of families. (Para. 35)

R.5 Need for Research Programs to Determine the Health, Social and Economic Status of all Age Groups

(a) Since nutrition is the basis of good health, poor nutrition constitutes a major health problem. (Para. 36)

(b) A relationship has been shown between the nutritional and the socio-economic status of different groups. (Paras. 37-38)

(c) It is recommended that more research be initiated in Canada to study this important question. (Para. 39)

R.6 Need for More Closely Controlled Production and Sale of all Foods for Human Consumption

(a) It is evident that contaminated food is being sold through normal channels of merchandising. The



to great physiological and mental

to it is represented as a  
relation to this group in  
the white and junior high schools.

(Page 24)

2. The first of the main points in the following

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(a) The study of the main points and  
necessity in the present state of

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(b) The study of the main points is the basis

of good health, and the study of

constitutes a major health

problem. (Page 26)

A policy study has been shown

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Food and Drugs Directorate should  
be given more personnel to adequately  
supervise and control food production  
and sale. (Para. 40)

(b) It is recommended that the Food  
and Drugs Directorate have on their  
staff at an administrative level a  
fully qualified nutritionist to help  
protect the public. (Para. 41)







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THE CHAIRMAN: Thank you, Dr. McLaren.  
Miss Girard?

COMMISSIONER GIRARD: On page 12 you state that the Department of Household Science has adequate facilities to accommodate one hundred students in each year of the course and that in recent years graduating classes have varied from only 11 to 25 student. On the other hand we people in hospitals know of the great shortage of dieticians and nutritionists in our institutions. Is there something that can be done, when you have these facilities, to get these people in here? Have you thought of male students?

DR. McLAREN: We have thought of male students. In the United States there have been some male students entering the program. In Canada we seem to be a little further behind in that regard. We have the facilities and it is unfortunate that we cannot train more people. I think the admissions of in-course scholarships will add both men and women to the recruiting program. Insofar as integrated internship program which has just started in Ontario, and has been a pilot project, that has increased the interest of a number of students going into dietetics, but they are not staying on the job once they are in. The turnover is quite large. This integrated internship program gives them a source of money during the summer which they can use to pay their fees. They still need more money to go to university since it is an expensive proposition at our university. I might point out at McDonald Institute at the Department of Agriculture their fees





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are much lower and their living conditions are much less and they have a greater number of students.

COMMISSIONER GIRARD: With the internship, doing away with the last full year of internship, the students have to do it in three summer sessions instead of a full year?

DR. McLAREN: Three summer sessions plus four and a half months, five months at the end. I think some hospitals would like to have the year program and some hospitals be integrated, some step by step. Some hospitals at this point think they would like to have the year program.

COMMISSIONER GIRARD: Do you find by having this internship program during the summer you have enough supervising staff to be able to give them a good internship program, the same as the year program?

DR. McLAREN: I think all the dieticians would answer that question in the affirmative. I think that they don't have too many students in the summer, just to keep away from having lack of supervision. The other thing that is important is that the students become interested in the field in the integrated program and their courses in subsequent years mean that much more to them.

COMMISSIONER GIRARD: The students wouldn't feel they are brought in in the summer to replace staff instead of getting education?

DR. McLAREN: They do replace staff. That is why it doesn't cost the hospital so much insofar as they employing replacements. The first summer they





and much lower and their living conditions are much  
 less and they have a greater number of children.  
 The situation is very different with the women  
 and, they work in the last full year of marriage,  
 the husbands have to be in three years, and  
 the end of a full year.

Dr. McNamee: Three women students  
 have been and a few months, five months at the end.  
 I think some hospitals would like to have the year  
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Dr. McNamee: I think you find  
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 a good internship program, the same as the year program.

Dr. McNamee: I think all the directors  
 would agree that question in the affirmative, I think  
 that they don't have too many students in the summer,  
 just to keep away from having too of a congestion. The  
 other thing that is important is that the students  
 become interested in the field in the internship program  
 and their courses in the regular years and that makes  
 sense to them.

Dr. McNamee: I think the students  
 wouldn't and they are interested in the summer in  
 people's state and of service activities.  
 Dr. McNamee: They do not have much  
 and as for the last part of the hospital as well as this  
 and applying experience, the first year they



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4 don't stay on one job because there are many people  
5 going on holidays, and they shift from one job to the  
6 other. Then they come to the supervisor level and  
7 replace food supervisors in the second summer. In the  
8 larger hospitals they are replacing assistant dieticians  
9 in the third summer, so that they have a graduated  
program and it has worked out very well.

10 COMMISSIONER GIRARD: Are there many  
11 schools, I know you are presenting this brief from your  
12 own school, but are there many schools in Household  
13 Science that have the facilities to train many more  
student than they are now training?

14 DR. McLAREN: I can't say. I would  
15 say no without thinking in terms of specific ones. I  
16 would the University of Alberta and the University of  
17 Saskatchewan are concerned about space. I don't think  
18 the University of British Columbia and the McDonald  
19 Institute, McDonald College, both have plenty of space  
and they would like, I think, to have more students.

20 COMMISSIONER GIRARD: On page 17  
21 in line with your recommendation, I will read it:

22 "There are many ways in which food  
23 "intake has been correlated with the  
24 "ability of families to adjust to  
25 "stress conditions".

26 You then advocate nutritionists or someone in the welfare  
agencies,

27 "therefore it would seem reasonable  
28 "to have professionally trained  
29 "nutritionists at administrative and  
30



don't stay on one job because there are very few  
 being on holidays, and they shift from one job to the  
 other. When they come to the summer level and  
 replace food advisors in the second summer. In the  
 summer months they are replacing assistant directors  
 in the third summer, so that they have a year-round  
 program and it has worked out very well.

COMMISSIONER OF THE FOOD AND AGRICULTURE  
 DEPARTMENT, I know you are presenting this budget for your  
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COMMISSIONER OF THE FOOD AND AGRICULTURE DEPARTMENT: On page 17  
 in line with your recommendation, I will read:  
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 "Institute has been correlated with the  
 "ability of facilities to relate to

You then advocate participation of someone in the program  
 "Therefore it would seem reasonable  
 "to have professionally trained  
 "technicians at administrative and





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3 "other levels of welfare agencies.

4 "In this way reliable data could be

5 "obtained to predetermine the financial

6 "requirements for any family".

7 Would that be the only or the major reasons that you  
8 would want to see fully trained nutritionists in  
9 welfare agencies or would her role not also be to teach  
10 homemakers and people that are going into home management  
11 and household management and budget management for food  
and other things?

12 DR. McLAREN: That applies in the  
13 visiting homemakers organization, for example, that have  
14 a direct line which they teach the homemakers to teach  
15 the people.

16 COMMISSIONER GIRARD: This would be  
17 one of her functions?

18 DR. McLAREN: This would be one of  
19 her functions, but they have more than one nutritionist  
20 do that. Generally if there is a welfare agency --  
21 I am ashamed I don't know the name, they were the  
22 Neighbourhood Workers but they have changed it in the  
23 last week or two. They have one nutritionist and  
24 her main area is management and nutrition. A lot of  
25 trouble comes from lack of finances because if you  
26 can look after the food and get that more valuable in  
27 a nutritional sense at lower cost this takes away a  
28 lot of the troubles for the family. In the visiting  
29 homemakers where they have one or two or three  
30 nutritionists at different levels they do teach the  
people, but these are counselling agencies and the





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4 nutritionist there comes into the financial picture.

5 COMMISSIONER GIRARD: Thank you very  
6 much.

7 COMMISSIONER FIRESTONE: Dr. McLaren,  
8 in your recommendation 5 on page 2 you say and I quote:

9 "It is recommended that more research  
10 "be initiated in Canada to study this  
11 "important question".

12 Does this recommendation refer to research work covered  
13 in paragraph A and B or does it cover a broader area?

14 DR. McLAREN: I think we would like  
15 to have it cover A and B. If we could get that done  
16 I think we would have a truer picture of the broader  
17 area. If I understand your question correctly, if we  
18 could find out the nutritional socio-economic services  
19 of different groups across Canada we would know much  
20 more about the health of the people.

21 COMMISSIONER FIRESTONE: I am just  
22 trying to establish what kind of research you have in  
23 mind. Do you consider that the relationship between  
24 nutrition and economics or are you also concerned with  
25 research of the nutritional values of particular foods  
26 and their effect on the state of health?

27 DR. McLAREN: I think we are interested  
28 primarily in the effect of food on the state of  
29 health. I think this is true, but teaching methods  
30 which people are going to use will depend to a large  
extent upon the socio-economic status of the people.  
I think we have to know what sort of methods we could  
use with each group. It is one thing to get one level

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3 of economic group, talk to them and you turn to another  
4 level and you have to use different methods.

5 COMMISSIONER FIRESTONE: I quite see  
6 that, Dr. McLaren, but I am trying to find out, to have  
7 a clear understanding whether you are recommending  
8 assistance be made available to cover research in the  
9 field of nutrition and its impact on health plus the  
10 relationship between the nutrition and economic status,  
11 or only one of the two areas?

12 DR. McLAREN: No, we would like to see  
13 it in both.

14 COMMISSIONER FIRESTONE: Because I  
15 didn't read this into the recommendation as it is  
16 stated here, and I am grateful to you for your explanation.

17 The next question is who should do  
18 this research? I looked at your paragraph 39 and I find  
19 that you recommend that the municipal, provincial,  
20 federal agencies concerned with the health of the nation  
21 should employ sufficient staff to implement this type  
22 of research in their health programs. Is your  
23 recommendation that this type of research covering area  
24 one or area two as we have just discussed be done by  
25 government agencies only?

26 DR. McLAREN: No, I don't think we  
27 want to recommend that. I think an example in point  
28 is the fact that the Ontario Hospital Services Commission  
29 is thinking in terms of doing research of this kind  
30 in the rehabilitation of patients and the welfare  
group in the Province of Ontario set up a new position,





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DR. McLAUGHLIN: No, I don't think we

want to recommend that. I think an example in point is the fact that the Ontario Hospital Services Commission is looking in terms of doing research of this kind in the relationship of patients and the welfare group in the Province of Ontario set up a new position,



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4 and one of the characteristics of that position is to  
5 do research on relationship of nutrition and socio-  
6 economic aspects. I think they want a little bit of  
7 help, more money. I don't think it is for the  
8 government, but I think government has to give it their  
9 blessing, anyway.

10 COMMISSIONER FIRESTONE: In other  
11 words you are recommending a more comprehensive research  
12 program than you indicated in paragraph 39 consisting  
13 of research done through government agencies and other  
14 agencies whether they are university or private  
15 organizations, et cetera, is that correct?

16 DR. McLAREN: That is correct.

17 COMMISSIONER FIRESTONE: As far as  
18 research done at the university and at private  
19 institutions, do you feel there should be some financial  
20 support for such research forthcoming from the Federal  
21 Government?

22 DR. McLAREN: I think that it would  
23 be well if it were, and it could do two things: You  
24 could get some of the answer to this question and also  
25 you might be able to rehabilitate some more matured  
26 people, as I mentioned in another part of the brief,  
27 and get these mature women who are now free of family  
28 responsibilities and are willing to come back into the  
29 field, but generally finance is the blocking factor.  
30 I think if government, if we could get help from the  
Provincial and Dominion Governments, either money  
directly as scholarships or to the university so they  
could pay these people more remuneration, I think it



and one of the characteristics of that position is to  
 to research on relationship of nutrition and social  
 government, but I think government has to give it their

COMMISSIONER: I think

word, you are recommended a more comprehensive research  
 program than you indicated in paragraph 18 consisting  
 of research done through government agencies and other  
 agencies whether they are university or private  
 organizations, at centers, is that correct?  
 DR. McLENNAN: That is correct.

COMMISSIONER: As far as

research done at the university and at private  
 institutions, do you feel there should be some financial  
 support for such research forthcoming from the Federal  
 Government?  
 DR. McLENNAN: I think that it would

be well if it were, and it could be too thin. You  
 would get a lot of the answer to this question and also  
 you might be able to reveal things some more matured  
 people, as I mentioned in another part of the paper,  
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 field, but generally finances in the academic field.  
 I think if government, if we could get help from the  
 Federal and Foundation Governments, either money  
 directly as scholarships or to the university so they  
 could pay these people more remuneration, I think it





McLaren

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would be possible to get a lot of them interested and therefore we would have more dieticians, more nutritionists.

COMMISSIONER FIRESTONE: And also you might feel that the universities are an important place to do this type of research?

DR. McLAREN: Yes sir. I think we have made a start. It is a slow process when there is such a lack of students.

COMMISSIONER FIRESTONE: Would you feel if you had funds available for a research program you would be able to attract adequately trained research people to do this type of work?

DR. McLAREN: I wouldn't say we could attract adequately trained people because I don't think they exist at the moment. I think we would have to train them, but we need money for this class of student.

COMMISSIONER FIRESTONE: So that you would proceed in stages: You would first train them and you would then attract them to do the research?

DR. McLAREN: In the first place we would train them in doing research and we would hope they would be interested to continue.

COMMISSIONER FIRESTONE: That is a very clear explanation, and thank you very much. My last question refers to recommendation 6(b) on page 3 where you recommend that the Food and Drug Directorate have on their staff at an administrative level a fully qualified nutritionist to help protect the public. Has the Food and Drug Directorate a nutritionist on its staff at the moment?



...the point is to get a lot of them interested and  
...we would have some criticisms, more constructive  
...and also

...you might feel that the universities are an important  
...to do this type of research?  
...Dr. McMillan: Yes sir, I think we

...have made a mistake. It is a great process when there is  
...such a lack of interest.  
...WOMAN: YES, I THINK SO. WOULD YOU

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...and then they would be able to do the work. It  
...but question before to be considered (5) on page  
...I think we need more that the first two have discussed

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...but question before to be considered (5) on page  
...I think we need more that the first two have discussed



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4 DR. McLAREN: I think it has nutritionists  
5 on its staff, but they are not at a high enough level to  
6 give too much leadership in the way of nutrition.

7 COMMISSIONER FIRESTONE: In other  
8 words, you would wish a senior and experienced person to  
9 be placed on the staff, and that person being, as you say,  
10 a fully-qualified nutritionist. Now, what would that  
11 senior person do that is not being done at the present  
12 time?

13 DR. McLAREN: Well, I think we cite  
14 in this brief two articles, Scurvy and Rickets are Still  
15 With Us, which was written by Dr. Elizabeth Chant  
16 Robertson, and published in 1957, which is a good discus-  
17 sion of the extent that we have of scurvy and rickets,  
18 which are two deficiency diseases, and we think in  
19 terms of scurvy being finished a couple of centuries ago.  
20 And then Dr. Grewar's Report on Infantile Scurvy in  
21 Manitoba. I think we have no right to have these in  
22 existence in Canada at the present time if we had  
23 adequate supervision.

24 COMMISSIONER FIRESTONE: Well, this is  
25 a very desirable statement. I am just trying to visualize  
26 what this particular person would do to help bring about  
27 this desirable state of affairs which you describe?

28 DR. McLAREN: Well, I think the thing  
29 is that we know that scurvy and rickets are caused by  
30 lack of vitamin C and D. Now, when vitamin D was put in  
milk in the form of radiation, rickets decreased very  
rapidly. Then we could do the same thing for scurvy.  
We could have sources of vitamin C which children would be



DR. MELARINI: I think it has nutritional

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give the much leadership in the way of nutrition.  
In other

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We could have sources of vitamin C which children would be





McLaren 10401

getting normally. For instance, as Dr. Robertson points out, put it in evaporated milk, and this is the way in which the children are fed, and if it were in there it would protect them against scurvy. Of course, it is an educational program. We could have people educated so that if the child does not like orange juice they won't give it Orange Crush, which happens.

COMMISSIONER FIRESTONE: Do I understand that you would visualize this nutritionist to make also a contribution to the education program?

DR. McLAREN: I think you have to, and if a person was in there at that level they could.

COMMISSIONER FIRESTONE: I do not deny the desirability of such an educational program. It perhaps would not be easy for the Food and Drug Directorate to sponsor such a program. Presumably such an educational program might be done through another form, through another institution?

DR. McLAREN: Yes, but the main responsibility lies with the Food and Drug. If they won't recognize the need, then it cannot be done. Is that not true?

COMMISSIONER FIRESTONE: Well, we are grateful to you for your views, and thank you very much.

COMMISSIONER BALTZAN: In connection with your auxiliary personnel, on Page 2 you state: "The need for reorganization and training", and then we must presume that there is no such training in progress now, or is there?

DR. McLAREN: Well, the Ontario Hospital







McLaren 10402

Association and the Ontario Dietetic Association has had a course for food supervisors for the last two years. The first year they had six students and the second year seventeen, and the Ontario Hospital Association, which has shouldered most of the expense, and the Ontario Dietetic Association has provided the lecturers. This is an expensive proposition and they do not want to carry it on much longer. We suggest in this brief that there are existing educational organizations, for example trade schools, vocational schools, and technical high schools, in which these people could be trained, and at the same time have an education along with it. We suggest that because of the fact that there is very little status amongst the workers in these food services organizations in hospitals, and that causes a lot of the turnover.

COMMISSIONER BALTZAN: In this training in vocational schools and technical schools and other institutions, would that be subject to the kind of training or activity say, of a girl who goes in to take a business course in a technical school? In other words, one would go in to be a hygienist, another would be for sanitation training and food management, or would it be a course to cover all of these things?

DR. McLAREN: I would hope that it would be a course to take in them all, because anybody who is going to work in foods needs to have training in these areas.

COMMISSIONER BALTZAN: So that they could fit in at certain levels, say, in industry, hospitals, or elsewhere?



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COMMISSIONER BARTON: In this training

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institutions, would that be subject to the kind of training  
or activity say, of a girl who goes in to take a business  
course in a technical school. In other words, one would  
go in to be a typist, another would be for sanitation  
training or food management, or would it be a course

in some of these things

MR. BARTON: I would hope that it

would be a course to take in this all, because another  
one is going to work in a hotel needs to have training in

these things

MR. BARTON: So that they

would be in at certain levels, say, in industry, hos-

pitals, or elsewhere





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# ROYAL COMMISSION ON HEALTH SERVICES

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DR. McLAREN: That is right, and I think it is true amongst even our own graduates that you have to give them a plan by means of which they can rehabilitate themselves, and this is apparent too in the food service people. A lot of people would like to raise their qualifications, but they don't know how.

COMMISSIONER BALTZAN: Would such training fit some of these people to go into some of our restaurants?

DR. McLAREN: That is right.

THE CHAIRMAN: Thank you, Dr. McLaren, for having taken so much trouble in the preparation of the brief and presenting it, and being here this afternoon. We are grateful to you.

DR. McLAREN: Thank you, sir, it was a pleasure.

THE CHAIRMAN: We will rise until 9:30 tomorrow morning.

---Adjournment.



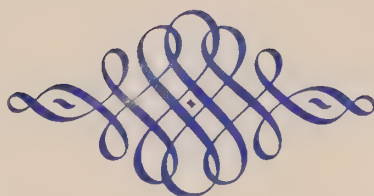


# ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS  
HELD AT  
TORONTO  
ONT.

VOLUME NUMBER :  
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COMMUNIST PARTY OF CANADA  
SUBBURY DISTRICT MEDICAL SOCIETY

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 17th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVIT M. BALTZAN

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MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE



held in Toronto, Ontario,  
on the 17th day of May, 1962.

WITNESSES:

Chief Justice EMMETT M. HALL

MRS. ALICE GRANT, R.N.

MR. C. L. TILGNER

MR. ALFRED P. VAN WAGEN

MR. M. WALLACE MONTGOMERY, C.O.

MR. J. J. TROTT

MR. DAVID H. BARTON

WITNESSES:

MR. F. M. HALL, C.O.

WITNESSES:

MR. ALFRED P. VAN WAGEN

WITNESSES:

MR. ALFRED P. VAN WAGEN

WITNESSES:



---On resuming at 9:30 a.m.

THE SECRETARY: Mr. Chairman, the next brief will be that of the Canadian Manufacturers' Association and will be known as exhibit 286. Mr. Whitelaw will introduce his group to the Commission.

---EXHIBIT NO. 286: Submission by the Canadian Manufacturers' Association.

SUBMISSION OF  
CANADIAN MANUFACTURERS' ASSOCIATION

APPEARANCES:

Mr. L.F. Wills  
Mr. K. Hallsworth  
Mr. J. H. Perry  
Mr. J.G. Connor  
Mr. M. O'Brien  
Mr. J.C. Whitelaw  
Mr. H.S. Shurtleff  
Mr. E. R. Barrett

MR. WHITELOW: Mr. Chairman, gentlemen of the Commission, may I first express the regrets of Mr. Draper, the Chairman of our National Industrial Relations Committee on his inability to be here this morning.

Unfortunately, a matter of the utmost urgency arose overnight, making it mandatory that he remain in Montreal today. His absence, I can assure you gentlemen, is a source of much disappointment I might say to both him and to us.

Next, may I express to the gentlemen of the Commission our real pleasure on being here this



---in morning at 9:30 a.m.

THE PROSECUTION: Mr. Swinton, the

first part will be that of the Canadian Manufacturers'

Association and will be known as Exhibit 100. Mr.

Whiteley will introduce his group to the Commission.

2nd Session by the Canadian  
Manufacturers' Association.

---EXHIBIT No. 100.

COMMISSION OF

CANADIAN MANUFACTURERS' ASSOCIATION

- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller
- Mr. J. H. Miller

of the Commission, may I first express the thanks of  
 the Commission, the Chairman of our National Industrial  
 Relations Committee on his kind letter to the effect that

Mr. Whiteley, a member of the staff  
 of the Commission, arrived here overnight, which it happened to be  
 Monday in Montreal today. His absence, I can assure  
 you gentlemen, is a source of much regret.  
 I am sure that you will find him and to me.  
 Next, may I address to the Commission  
 of the Commission my very sincere thanks for the



Whitelaw

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3 morning and being permitted to talk on this subject  
4 matter that is occupying your attention which is of  
5 such vital importance to the Canadian Manufacturers'  
6 Association.

7 I understand Mr. Chairman that it  
8 will be in order to present a summary of the presentation  
9 which has been in your hands for some time and following  
10 this, if it is your pleasure, we shall be happy to  
11 endeavour to answer any questions you may have.

12 THE CHAIRMAN: That is the procedure  
13 that we have been following.

14 MR. WHITELAW: We will be very happy  
15 to follow that sir. Before proceeding with the  
16 presentation of the summary, I would like to present  
17 my associates. On my immediate left Mr. L. W. Wills,  
18 vice-president and general manager of Honeywell Controls  
19 Limited. He is Chairman of our Committee on Social  
20 Security and he will be our chief spokesman and present  
21 the summation.

22 Mr. Ken Hallsworth, Director of  
23 Industrial Relations, Ford Motor Company of Canada  
24 Limited. Mr. J.H. Perry, Industrial Relations Manager,  
25 Brewers' Warehousing Company Limited. Mr. J.G. Connor,  
26 Supervisor, Insurance and Pension Department of the  
27 Steel Company of Canada Limited. Mr. Marrs, who is  
28 replacing Mr. O'Brien, who is manager of personnel  
29 accounting at Canadian General Electric Company Limited.  
30 Mr. E.R. Barrett, manager of our Industrial Relations  
Department of the Canadian Manufacturers' Association.  
Mr. H.S. Shurtleff, manager of our Insurance Department



10-11-1941

nothing and being permitted to talk on this subject  
rather than is occupying your attention which is of  
much vital importance to the Canadian War Relocation

will be in order to present a summary of the presentation  
which has been in your hands for some time and following  
this, if it is your pleasure, we shall be happy to  
endeavour to answer any questions you may have.

THE CHAIRMAN: There is one procedure

that we have been following.

MR. W. L. BROWN: We will be very happy

to follow that and, before proceeding with the  
presentation of the summary, I would like to present  
my associates. On my immediate left Mr. L. W. Willis,  
vice-president and general manager of Home Well Controls  
limited. He is chairman of our committee on Social  
Security and will be our chief spokesman and present  
the summary.

MR. W. L. BROWN: Director of

Industrial Relations, for the Government of Canada

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Industrial Relations, for the Government of Canada

Mr. W. L. BROWN: Director of  
Industrial Relations, for the Government of Canada

Mr. W. L. BROWN: Director of  
Industrial Relations, for the Government of Canada



Whitelaw

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and Mr. John Tiefenback, associate of Mr. Barrett's in the Industrial Relations Department.

Now if I may, I shall ask Mr. Wills to carry on.

MR. WILLS: Thank you sir. This then gentlemen is a summary of our brief.

The Canadian Manufacturers' Association welcomes this opportunity to appear before you and to summarize verbally points in the brief which was sent to you some time ago.

Our Association, consisting of some 6,400 members, who are responsible for about 75% of Canada's total manufacturing output, has followed with interest the work of your Royal Commission on Health Services since your study is of vital concern to all our members. Not only are we concerned from the point of view of our general interest as citizens, but the efficiency of our operations depends upon the well-being of our employees and, as major contributors to present health insurance schemes for both employees and their dependents, we have a vital concern with the financial impact of any proposals which you may advance for improving health services.

In the interest of brevity, I will make no attempt to read the complete submission, which has been placed before you, since I understand you have had opportunity to study this at your leisure, but will highlight some of the points which we would like to amplify. Reduced to the minimum, our recommendations can be summed up in the following four points:





and Mr. John L. Hendricks, associate of Mr. Hendricks in

Now if I may, I shall ask Mr. Willis

to carry on.

Mr. Willis: Thank you sir. This then

gentlemen is a summary of our program.

The Council on Health Insurance Association

tion welcomes this opportunity to appear before you and

to emphasize various points in the field which are

sent to you some time ago.

Our Association, consisting of some

1,000 members, who are responsible for about 75% of

Canada's total manufacturing output, has followed with

interest the work of your Royal Commission on Health

Services since your study is of vital concern to all

of us here. Not only are we concerned from the point

of view of our general interest as citizens, but the

efficiency of our operations depends upon the well-

being of our employees and, as major contributors to

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financial aspect of any proposals which you may

advance for improving health services.

In the interest of brevity, I will

make no attempt to read the complete submission, which

has been filed before you, since I understand you have

not opportunity to study that at your leisure, but will

highlight some of the points which we would like to

submit. Subject to the above, our recommendations

and the manner of their implementation are as follows:



Wills

10407

1. It is recommended that nothing be done which would hinder the present development of private health plans.

2. It is recommended that, in conjunction with the development of the voluntary health plans referred to, steps should be taken to permit the purchase of health insurance by those who by reason of age or pre-existing medical conditions would find difficulty in obtaining coverage. This should be done in such a way that rates of payment should be comparable to those paid by regular subscribers.

3. It is recommended that government funds continue to be devoted to the supplying of capital equipment such as hospital and treatment centres in areas where it is difficult for the scattered population to provide these for themselves.

4. In view of our belief that private voluntary health plans can best meet the needs of the vast majority of Canadians, it is recommended that no government-operated health scheme, applicable to Canadians generally, should be undertaken.

With your indulgence, I would like to further amplify on each of these recommendations.

1. It is recommended that nothing be done which would hinder the present development of private health plans.

The past 20 years have witnessed the establishment and growth of voluntary health plans to a marked degree. The rapid growth of these plans in the past 10 years testifies to their efficacy in satisfying



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3. It is recommended that government funds continue to be devoted to the supplying of capital equipment such as hospital and treatment centers in areas where it is difficult for the scattered population to provide these for themselves.

4. In view of our belief that private voluntary health plans can best meet the needs of the vast majority of Americans, it is recommended that government-operated health plans, applicable to certain categories, should be undertaken.

With your indulgence, I would like to submit briefly on each of these recommendations.

1. It is recommended that nothing be done which would hinder the present development of private health plans.

The past 40 years have witnessed the rapid growth of voluntary health plans in a marked degree. The rapid growth of these plans has been a result of their effectiveness in providing





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4 a basic need of Canadian people. These plans differ  
5 widely in nature and their very variety is of itself  
6 a virtue since it enables Canadians to choose a plan  
7 most suited to their particular needs and pocket-books.  
8 For another reason, flexibility in health plans is of  
9 prime importance because of the changing pattern of  
10 needs brought about by new concepts in the approach  
11 to medical practice. It is not so long ago that the  
12 big problem in medical care was the infectious diseases  
13 which normally required a few visits from the medical  
14 practitioner and relatively inexpensive drugs. Today,  
15 the tendency is to longer and more involved treatment  
16 and such elaborate specialties as psychiatry and  
17 geriatrics are becoming more important. At the same time,  
18 the so-called wonder drugs, while bringing about amazing  
19 results, are adding tremendously to the cost of  
20 medical care. We submit that any programme which attempts  
21 to meet the requirements of the population in a satisfactory  
22 manner must take all these factors into consideration,  
23 since it will have to provide a high degree of  
24 flexibility and it is doubtful that any single plan  
25 will be able to meet all requirements.

26 We have used the phrase "voluntary  
27 health plans" to refer to the existing plans and this  
28 voluntary element in itself confers an advantage,  
29 because there is an element of choice on the part of  
30 the participants as to whether they purchase any  
particular form of health protection or not, these  
plans must satisfy their needs if they are to survive.  
The voluntary aspect of such plans brings about an





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which in nature and their very variety is of itself  
a virtue since it enables Canadians to choose a plan  
most suited to their particular needs and pocket-books.  
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great importance because of the changing pattern of  
needs brought about by new concepts in the approach  
to medical practice. It is not so long ago that the  
big problem in medical care was the infectious diseases  
which usually required a few visits from the medical  
profession and relatively inexpensive drugs. Today,  
the tendency is to longer and more involved treatment  
and such elaborate specialties as psychology and  
oncology are becoming more important. At the same time,  
the so-called wonder drugs, while bringing about amazing  
results, are adding tremendously to the cost of  
medical care. We submit that any programme which attempts  
to meet the requirements of the population in a satisfactory  
manner must take all these factors into consideration,  
since it will have to provide a high degree of  
flexibility and it is doubtful that any single plan  
will be able to meet all requirements.  
We have used the phrase "voluntary  
health plans" to refer to the existing plans and this  
voluntary element in itself offers an advantage,  
because there is an element of choice on the part of  
the participants as to whether they participate and  
participate in health protection or not, whereas  
plans that satisfy their needs if they are to survive,  
the voluntary aspect of such plans before they are



Wills

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4 element of personal concern for efficient operation which  
5 is important in minimizing abuses. While it is true  
6 that since many of these plans are provided through  
7 employers, there is a tendency for this sense of personal  
8 participation to be submerged, nevertheless, the  
9 individual employee is aware that if he expresses his  
10 feeling about such plans either directly to his employer  
11 or through his union committee, changes can be  
12 effected.

13 Finally, the element of keen competition  
14 between plans which exist at the present time, acts as  
15 a stimulus to efficiency. Without such competition  
16 between plans, there would be a great danger of  
17 administrative costs of health insurance mounting  
18 rapidly.

19 2. It is recommended that in conjunction  
20 with the development of the voluntary health plans  
21 referred to above, steps should be taken to permit the  
22 purchase of health insurance by those who by reason  
23 of age or pre-existing medical conditions would find  
24 difficulty in obtaining coverage. This should be done  
25 in such a way that rates of payment should be comparable  
26 to those paid by regular subscribers.

27 We are aware, MR. Chairman, that there  
28 are certain limitations in existing health plans. There  
29 are sectors of the population which are inadequately  
30 covered and do require special treatment. This is true  
in particular of three groups who might seek in vain  
for means of prepayment for their health service  
requirements. These groups are:



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 in such a way that rates of payment would be based on  
 to some basis for medical underwriting.  
 We are aware, Mr. Chairman, that there  
 are certain limitations in existing health plans. These  
 are because of the population which are insured and  
 covered and do require careful treatment. This is true  
 in particular of those groups who might seek in this  
 for some of pressure for their health coverage  
 to be made more available.





1. Those who by reason of age find the cost of health insurance prohibitive, if it is available at all.

2. Those who are prevented from obtaining health coverage by reason of pre-existing medical conditions.

3. Those who are unable to afford the cost of health insurance.

The first two groups require special treatment because it is difficult for private plans as presently constituted to offer protection to them since there is almost a certainty that the necessary premium to cover the probable claims experience of these groups would be prohibitively high. Persons of advanced age are entering a period of life, when long complicated sicknesses are bound to be more frequent. There are, also, those in the population who have long standing medical conditions which make it a certainty that they are going to require a great deal of medical attention. If anything, their need for protection is more urgent than that of the normal population. We suggest that there are two ways in which these problems might be met:-

(a) The purveyors of private health plans could be encouraged to make special arrangements for pooling such risks, thus, spreading the impact of cost over larger groups.

(b) Government funds might be used to provide financial supplements to assist in carrying these high-risk cases.





1. Those who by reason of age find the cost of health insurance prohibitive, as it is available to all.
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- (a) The purchase of private health plans could be encouraged to have special provisions for people such as this, spreading the losses of cost over larger groups.
- (b) Government funds might be used to provide financial aid to state health plans.



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4 With regard to the third group, we  
5 have suggested that a special study is necessary to de-  
6 termine the best way in which to provide for the health  
7 care of those unable to pay for health insurance. It  
8 is repugnant to all of us to think of any resident of  
9 Canada suffering ill-health as a result of inability  
10 to pay for medical services. At the same time, it is  
11 necessary to make sure that those who might meet their  
12 own requirements in this regard are given every possible  
13 encouragement to do so. We, therefore, suggest that  
14 a study of this problem might with advantage be made  
15 by your research staff in consultation with social  
16 workers and other experts in this field.

17 3. It is recommended that government  
18 funds continue to be devoted to the supplying of  
19 capital equipment such as hospitals and treatment centres  
20 in areas where it is difficult for the scattered  
21 population to provide these for themselves.

22 There was a time when the vast majority  
23 of treatments for ill-health were carried on in the home  
24 of the patient or the physician's crowded consulting  
25 room. Today's modern techniques of treatment require  
26 vast arrays of complicated apparatus, together with  
27 technically-trained staff to operate them, in order  
28 that a proper diagnosis can be determined and appropriate  
29 treatment provided. It is very necessary, therefore,  
30 that Canada continue to devote large sums of money to  
the building and equipping of hospitals, diagnostic  
and treatment centres. While most of our populated  
areas still have unsatisfied requirements in this regard,





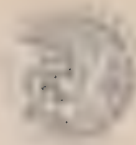


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4 some of the rural areas have perhaps even more urgent  
5 needs. Attention to this aspect of the problem will  
6 help relieve yet another major problem which must be  
7 resolved if all Canadians are to be assured of adequate  
8 health services. This problem is the uneven distribu-  
9 tion of medical practitioners throughout Canada. In  
10 1960, Canada had a ratio of one doctor to 879 persons  
11 which compares favourably with other nations. However,  
12 the fact that the ratio in Newfoundland is one doctor  
13 to every 1,682 persons compared to one doctor to every  
14 780 persons in Ontario, shows an uneven distribution  
15 which is undesirable. The provision of adequate hospital  
16 services together with modern diagnostic and treatment  
17 facilities would encourage young doctors to enter  
18 practice in the more sparsely populated areas thus  
19 tending to correct the uneven ratio to which we have  
20 referred. It may well be that this recommendation alone  
21 would absorb all the government funds that Canada  
22 should afford for health services for some time to come.

23 4. In view of our belief that private  
24 voluntary health plans can best meet the needs of the  
25 vast majority of Canadians, it is recommended that no  
26 government-operated health scheme, applicable to  
27 Canadians generally, should be undertaken.

28 We are aware that you have heard many  
29 representations which strongly advocate some form of  
30 national health scheme; that is, a compulsory government-  
sponsored plan for the payment of medical expenses by  
means of revenue obtained through taxes or a specific  
levy on all citizens. Many will point to examples of  
health plans in other countries, and in particular to





...of the rural areas...  
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...in view of our belief that we will be  
......  
...at least by the end of the year, it is hoped that  
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TORONTO, ONTARIO

Wills

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4 that in Great Britain. Yet there are many who feel that  
5 the United Kingdom plan has failed to live up to the  
6 golden promises which its proponents made before its  
7 adoption. Some of its supporters believe that, if  
8 medical services could be provided on an adequate scale,  
9 the community would become so healthy that medical services  
10 ultimately would scarcely be needed. Subsequent events  
11 have proven the fallacy of such a belief for the  
12 demand for health services has increased rather than  
13 declined. There are many reasons for this, of course,  
14 but certainly the British experience seems to indicate  
15 that it is very difficult to provide for an all-  
16 inclusive plan since the demand for health care appears  
17 to extend as the accessibility increases.  
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that is, it is certain. Yet the same man who feels that  
the "best" thing for him is "failed" to live up to the  
policy practices which the government has set before him.  
In addition, some of the same men believe that in  
medical services could be provided on an adequate basis,  
the community would become as healthy as that medical services  
currently would be. It is necessary to understand exactly  
how known the failure of such a belief for the  
demand on health services has increased rather than  
declined. There are many reasons for this, of course,  
but certainly the political error seems to indicate  
that it is very difficult to provide for a  
inclusive plan since the demand for health care appears  
to extend as the population increases.



Wills 10414

The Beveridge Report, on which the British National Health Service was based, set forth this objective for the scheme:

"A comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institution, general, specialist or consultant, and will ensure also the provision of dental, opthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents. The service should provide full preventative and curative treatment of every kind to every citizen without exception, without remuneration limit and without an economic barrier at any point to delay recourse to it."

Yet, despite these broad objectives, membership in private health insurance plans in the United Kingdom has risen from 100,000 in 1949 (the year after inception of the national health scheme) to over 1,000,000 in 1960. This continuing expansion in the demand for private health plans may well indicate that the National Health Scheme has failed to satisfy the full requirements of many of the British people. Those who suggest that Canada adopt a similar plan, should satisfy themselves that such a plan is likely to provide for public requirements to a higher degree here than it apparently is doing in Great Britain.

One of the basic questions which must





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services, training and of welfare and rehabi-  
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health service has failed to satisfy the full requirements  
of many of the British people. Those who suggest that  
Canada adopt a similar plan, should satisfy themselves  
that such a plan is likely to provide for public require-  
ments in a far less degree than it apparently is doing  
in Great Britain.



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Wills 10415

be considered in contemplating a national health scheme is that of cost. We believe firmly in Canada's future, but this future can only be assured if Canada's economy is allowed to operate on sound principles. Heavy social security costs no matter whether they are met through taxes or in the form of direct levies, must eventually be charged as an added burden to the cost of goods and services produced in Canada. Today, as never before, Canadian industry is faced with vigorous world-wide competition for markets. Apart from any contemplation of health insurance we are already faced with sharply rising costs for social welfare in Canada. The Unemployment Insurance Fund is in such serious condition that it was considered necessary to establish a Committee of Enquiry, charged with the responsibility of finding means of restoring the fund to solvency. An increase in payments under the Old Age Security Act has been recently announced. Despite this the problem of security for the aged is being widely discussed and many are advocating the addition of a "second-deck" in the form of a contributory pension scheme. Within recent years, the provinces of Canada have established government sponsored hospital plans. Without exception these plans are experiencing financial difficulty because of the rapidly rising costs. All of these things threaten to add considerable sums to the cost of Canadian social welfare at a time when rising competition threatens most seriously our goods-producing industries. None of these things can be taken in isolation. Any proposals to provide for a national health scheme must be considered as part of the total picture and







Wills 10416

any recommendations advanced must be based on the total effect of all social welfare costs on the economy.

Any national scheme of health insurance would undoubtedly be subject to a great many abuses, which are very difficult to control. If medical facilities are made easily accessible to all members of society at no apparent immediate cost to themselves, there is good reason to expect that these facilities would be subject to over-use to a degree that might warrant the label "abuse". This abuse or over-use appears almost impossible to control and is one of the basic reasons why the cost of such schemes tend to skyrocket.

There can be no doubt that the provision of any form of national health scheme would be very costly to Canadians.

In Great Britain before the National Health Scheme started, its cost was predicted to be 170 million pounds. Actually, in the first year of operation the cost rose to 400 million pounds and now the annual cost is exceeding 800 million pounds. There are many factors which cause such rapid increase in cost, but these figures do serve to point up the difficulty of adequately estimating the cost of this type of service in advance. It has been conservatively estimated that, in Canada, to provide for physicians' services only, would require 450 million dollars a year. In the light of Britain's experience, not to mention the experience in Canada of the hospital plans already established, it can be assumed that this figure would rapidly increase. It is disturbing to contemplate the results if the Canadian





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any restriction, however, must be based on the effect of all social welfare costs on the economy.

Any national scheme of health

insurance would, therefore, be subject to a great many

difficulties, which are very difficult to control. It is not

impossible to make such a scheme subject to all the

costs of no expenditure in health care to themselves, there

is good reason to expect that these difficulties would be

subject to one - but to a degree that might prevent the

idea "national", this is not an over-estimate either.

insurance to control and as one of the main reasons why

the cost of such schemes would be astronomical.

There can be no doubt that the problem

of any form of health insurance would be very costly

to ourselves.

In Great Britain before the war

health insurance existed, its cost was estimated to be 10

million pounds. Actually, in the first year of operation

the cost was 100 million pounds and now the annual

cost is over 800 million pounds. There are many

reasons why this cost has risen so much, but

these are not the reasons for the difficulty of

estimating the cost of this type of service in

general. It has been consistently estimated that, in

general, the cost of a national health service would

be about 100 million pounds a year. It is not

impossible to estimate the cost of the service in

general. The health service is already established, it is

not a new service and it is not a new service. It is

impossible to estimate the cost of the service in



Wills 10417

cost pattern should follow the same rising curve as did the British National Health Scheme.

We realize, of course, that a national plan would relieve Canadians of costs which they are already meeting but it is easy to be over-optimistic in this regard. The cost of a comprehensive government health plan would have to be met either by taxation or some form of direct levy on participants. Experience shows that direct levies of this sort are seldom set high enough initially to cover the whole cost. The difference, therefore, must be met through taxation. Increased taxation will inevitably be reflected in the price of goods produced in Canada thus producing a further weakening of our competitive position. For this reason, there is serious danger that the cost of a national health scheme would have a harmful effect on the Canadian economy.

Finally, we are concerned about the effect of a national health scheme on those members of the community who must provide these services. It is imperative that ways be found to make the study of medicine more attractive to young men. To do this it is necessary to make sure that the reward of the career seems sufficient recompense for the years of arduous study. Canada has been dependent on immigration for the supply of an average of 337 qualified physicians per year over the past ten years. Even if this rate of influx continues a considerable increase in graduation rate is required if Canada is to maintain its present physician-population ratio in the light of anticipated population increases.



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costs of the various services, and the

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also could relieve the burden of costs which they are

already meeting but it is easy to see over-optimism in

this regard. The cost of a comprehensive government

health plan would have to be met either by taxation on

some form of direct levy on personal assets, expenditure

above that which is allowed at this point, or some other

means initially to cover the whole cost. The difference,

however, must be met through taxation, increased

taxation will inevitably be levied in the case of

gross proceeds in various forms producing a certain degree

ing of our respective activities. On this point, there

is serious danger that the cost of a national health

scheme would have a harmful effect on the economy.

Finally, we are not alone in this

effect of a national health service on the economy at the

point of view of the whole economy. It is a matter

of fact that we are faced to make the study of national health

services to be made. It is true it is necessary to

make a study of the whole economy and the health service

services for the whole of the economy. (The study has

been made and is being made in the supply of the

services of the health service and the supply of the

public health service. This is the rate of public health

services in the health service and the supply of the

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Wills 10418

We are afraid that a state-operated compulsory plan would do little or nothing either to attract qualified immigrants or persuade able students to enter medical colleges.

#### CONCLUSION

Since the end of World War II a great variety of voluntary health plans have developed under private auspices until, today, the majority of Canadian people enjoy some protection. These plans are still showing every evidence of vigorous growth.

It is the opinion of the Canadian Manufacturers' Association that this development should be encouraged, because, firstly, it has the advantages which we associate with free enterprise, flexibility to adjust to changing needs and, a degree of competitiveness to act as a spur to administrative efficiency; and, in the second place, if any other system were introduced, the cost of the new plan would likely be of an order that Canada can ill-afford.

While the members of the Associations feel that their employees are, by and large, adequately protected, they are aware that certain classes of society are not as fortunate. It submits, therefore, that the Royal Commission on Health Services should make such recommendations as will assure to older citizens, and those with pre-existing medical conditions, the opportunity of acquiring health insurance. Facilities, too, are needed for the indigent.

A great deal needs to be done to improve health services in the regions of Canada which are not up to the high standard of the more populated parts. The







Wills 10419

provision of capital equipment such as hospital and treatment centres should have a very high priority. To direct funds away from such projects would be to detract from the objective of the provision of adequate health services for all Canadians.

The Association is of the opinion that a government-sponsored health scheme would involve the country in vast expenditures for a plan that would in large measure either replace or duplicate present voluntary health plans. Wages paid by manufacturers in Canada are the highest in the world next to the United States. Employee benefit plans, which are provided in addition to wages, add materially to the labour-cost of Canadian goods. The level of taxation is already high and, as we have already pointed out, there is strong and continued pressure to expand social and welfare payments made by various levels of government. In the face of all this Canadian manufacturers must increase their ability to produce competitively, if we are to maintain even our present level of prosperity. The members of this Association are eager to see Canadian citizens enjoy the finest in health services, but would question that government operation will provide it. Such plans, we feel, could only result in increased cost to all Canadians.

This greatly augmented burden of cost arising from a national plan might possibly be justified if such a plan would meet the real needs of Canadians. However, there is reason to question whether such a plan would provide Canadians with the health services they





Wills

10420

expect. In his excellent study of the National Health Scheme, "Health through Choice", Mr. D. S. Lees summarizes his views as follows:

"The fundamental weaknesses of NHS are the dominance of political decisions, the absence of built-in forces making for improvement and the removal of the test of the market. These defects bring dangers for the quality of medical care that cannot be removed without far-reaching reform...My verdict would be that a monolithic structure financed by taxation is ill-suited to a service in which the personal element is so strong, in which rapid advances in knowledge require flexibility and freedom to experiment, and for which consumer demand can be expected to increase with growing prosperity. While from the point of view of the general health of the community NHS has not in any obvious way failed, it has given rise to problems that a more market oriented system would have avoided, and those problems are increasing in number and complexity. On the longer view, the most acute danger of NHS is that it will prevent the emergence of more effective methods of medical care."

This may well contain a less for  
Canada.

Thank you very much.

THE CHAIRMAN: Thank you, Mr. Wills.







Wills 10421

We might have just some information on the basis of the constituency for whom you speak this morning. Your brief shows you have 6,400 members. What area, if any, in Canada is not included, what area of the manufacturing industry is not included in your Association, or is there any?

MR. WILLS: Mr. Justice Hall, I don't think there is any area of manufacturers or any geographical area that is not represented by our Association. I believe, sir, Mr. Whitelaw would be better able to give a break-down of those figures.

MR. WHITELAW: I would subscribe to what Mr. Wills has just said, Mr. Chairman. We have representation in something over 1,600 communities from one end of the country to the other. I would say that all segments of the manufacturing industry as represented in our membership. You may be interested in knowing this, we divide the country geographically for purposes of administration into five divisions. These divisions provide for adequate representation on our various committees, so that we have the means whereby the viewpoint of the manufacturing industry is made known, not only at the provincial level, but also through the provincial level at the national level.

THE CHAIRMAN: The reason for my question, you say the Association has 6,400 members who produce about 75% of Canada's total manufacturing output. I was wondering about the other 25% in terms of output.

MR. WHITELAW: We don't pretend, Mr. Chairman, to represent numerically all of the



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constitution. Now you speak this morning. Your  
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Mr. Willis: Mr. Justice Hall, I don't

think there is any area of manufacturing or any geographic  
area that is not represented by our Association. I  
believe, sir, Mr. Whitman would be better able to give  
a break-down of these figures.

Mr. Whitman: I would appreciate the

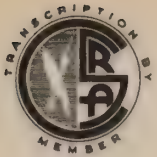
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question, you say the Association has 6,000 members who  
produce about 75% of Canada's total manufacturing output.  
I was wondering about the other 25% in terms of output.

Mr. Whitman: We don't produce.

Mr. Whitman: To represent roughly all of the



Whitelaw 10422

manufacturers of Canada as is evidenced by the 6,400 figure.

THE CHAIRMAN: What is the total manufacturing output?

MR. WHITELOW: The total manufacturing output of our production from our plants is represented to the tune of 75% from our 6,400 members.

THE CHAIRMAN: Are you in a position to give us some reasonable approximation of the number of employees employed by your members throughout Canada?

MR. WHITELOW: I wonder....

THE CHAIRMAN: That is the working force of the 6,400 members.

MR. WHITELOW: Mr. Chairman, I wonder if I might attack that through another way and give you something of a more degree of accuracy. We have for the last fourteen years been issuing a questionnaire each year with the object of determining the break-down of the sales dollar in the manufacturing industry. We have just completed that task for the year 1961, which incidentally, shows a return of 4.9 sales on the dollar of the manufacturing industry.





Whitlock 1951

Manufacturers of Canada as is evidenced by the 1951

THE CHAIRMAN: What is the total

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MR. WHITLOCK: The total manufacturing

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Whitelaw

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COMMISSIONER McCUTCHEON: Pre-tax or  
post-tax?

MR. WHITELAW: Pre-tax. The number of  
replies is something just under 1,100, which gives you  
a return of somewhere around 15, 16, 17% of our member-  
ship and the number of employees, and this is averaged  
over a 12-month period of the fiscal year, to use round  
figures, say, 490,000. That is in terms of those respon-  
ding, that is the 1,100 firms that have replied.

THE CHAIRMAN: Somewhere between 16 and  
20%?

MR. WHITELAW: Yes, sir.

COMMISSIONER FIRESTONE: What proportion,  
what total output or sales volume do these firms repre-  
sent?

MR. WHITELAW: I don't have that infor-  
mation, Doctor.

COMMISSIONER FIRESTONE: You see, sir,  
if these are large firms, you cannot multiply out to  
get at a 100% coverage.

MR. WHITELAW: I fully appreciate that,  
Doctor. I would not wish to convey that impression.  
I am merely using these figures as a means of accurate  
reply to your question.

THE CHAIRMAN: Would it be reasonably  
possible to get this information for us?

MR. WHITELAW: Yes, we would be very  
happy to do so.

THE CHAIRMAN: The number of employees?

MR. WILLS: As a matter of interest,



100-1-100

MR. WHITMAN: The matter of  
the matter is concerning the fact that the  
a matter of management is, in fact, the matter  
ship and the matter of employees, and this is a matter  
over a 12-month period of the fiscal year, and the matter  
business, and, 100,000. That is in terms of the matter  
thing, that is the 1,000 firms that have registered.  
and the matter is somewhere between 10 and

100

what total output in sales values do these 100 firms have?

MR. WHITMAN: I don't have that figure.  
action, however.  
a 100,000 figure. You see, sir,  
if these are 100,000 firms, you can't multiply that by  
get at a 100,000 figure.

MR. WHITMAN: I don't appreciate that.  
I don't know what a 100,000 figure means.  
I am not saying that figure is a matter of 100,000  
reply to that question.

MR. WHITMAN: I don't know what it means.  
possible to get this figure for 100?

MR. WHITMAN: Yes, we would be very  
happy to do so.

MR. WHITMAN: The matter of management  
MR. WHITMAN: Is a matter of interest.



Wills

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I think that 75% of our membership is composed of firms with less than 100 employees.

THE CHAIRMAN: You say 80% in the brief. We would like to be able to translate that into a figure, in terms of Canada's 18,500,000 population.

MR. WHITELAW: I would be very happy to get that information for you.

THE CHAIRMAN: Because the next question is, you say that you have many employer-employee agreements covering health services. Are you able to give us the number of employees covered by these plans for whom health services are provided?

MR. WILLS: The latest survey that we have is one taken in 1959, so it is three years old, at which time a total of 1,497 firms responded to the questionnaire. 1,116 carried medical and hospital plans, 76%. Now, if we might take a second here, going back into the breakdown of the 1,497 firms that responded to the questionnaire.

THE CHAIRMAN: That is 1,497 of 6,400?

MR. WILLS: That is right, sir. There may have been, and probably was, less than 6,400 member firms in 1959 as opposed to membership today. There were 94 of those 1,497 who employed more than 1,000 persons; 74 employed 500 to 1,000; 472, 100 to 500; and the balance of 857, 1 to 100 employees.

THE CHAIRMAN: Are you able to give the figures in totals?

MR. WILLS: No, sir, I am not.

THE CHAIRMAN: Is it possible to get





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I think that 15% of our membership is composed of firms with less than 100 employees.

THE CHAIRMAN: You say 15% in the policy, we would like to be able to translate that into a figure, is there of Canada's 18,500,000 population.

MR. WILBES: I would be very happy to give that information for you.

THE CHAIRMAN: Because the next question is, you say that you have many employee-owned enterprises covering health services. Are you able to give us the number of employees covered by these plans for other health services are provided?

MR. WILBES: The latest survey that we have is one taken in 1955, so it is three years old, at which time a total of 1,937 firms responded to the questionnaire. 1,115 carried medical and hospital plans, 75%. Now, if we might take a second hand, going back into the breakdown of the 1,937 firms that responded to the questionnaire.

THE CHAIRMAN: That is 1,937 of 8,500? MR. WILBES: That is right, sir. There may have been, and probably was, less than 8,500 firms in 1955 as opposed to membership today. There were 11 of those 1,937 who employed more than 1,000 persons; 14 employed 500 to 1,000; 140 to 500; and the balance of 857, 1 to 100 employees.

THE CHAIRMAN: Are you able to give the figures in detail?

THE CHAIRMAN: Is it possible to see



Wills

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that figure?

MR. WILLS: We will undertake to do that, Mr. Justice Hall. As a matter of interest, the participation in group medical and surgical coverage of those 1,497 responding was 1,292, or 86% at that time.

THE CHAIRMAN: These are groups?

MR. WILLS: That is right, sir.

THE CHAIRMAN: And your groups will be covered in the voluntary plans by commercial people and by whoever the firm does business with?

MR. WILLS: That is right, sir.

THE CHAIRMAN: You refer to a special pooling arrangement that you foresee and support for those who are ordinarily not insurable, either by reason of age or pre-existing conditions, that kind of thing. You see that within the industry itself, within the insuring industry?

MR. WILLS: Yes, sir.

THE CHAIRMAN: And are you aware of the proposal that was put forward here yesterday morning by and on behalf of the insuring companies, 115 of them, where they mentioned this type of a re-insurance pool?

MR. WILLS: I am aware of it only to the extent that my wife read it while I was having breakfast, sir, but it seemed to me that their proposals were identical, were very similar, to ours. That they feel, too, that there is a need for support and attention in this area.

THE CHAIRMAN: You appear to me for the



that figures?

W. Willis: We will undertake to do that, Mr. Justice Hall. As a matter of interest, the of those 1,487 responding was 1,252, or 84% of that

THE CHAIRMAN: These are groups?

THE CHAIRMAN: And your group, will be covered in the voluntary plans by commercial people and by whoever the firm does business with?

THE CHAIRMAN: You refer to a special pooling arrangement that you foresee and support for those who are otherwise not insurable, either by reason of age or pre-existing conditions, that kind of thing. You see that within the industry itself, within the insuring industry?

W. Willis: Yes, sir.

THE CHAIRMAN: And are you aware of the proposal that was put forward here yesterday morning by and on behalf of the insuring companies, 115 of them, where they mentioned this type of a re-insurance pool?

W. Willis: I am aware of it only to the extent that we often read it while I was having

breakfast, sir, but it seemed to me that their proposals were identical, were very similar, to ours. That they feel, too, that there is a need for support and attention on this area.

THE CHAIRMAN: You appear to be for the





Wills

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moment to go further in your suggestion of government supplements to those who are, I think the way you put it, your government supplement was to keep the premium down?

MR. WILLS: That is right. I think we suggested that it might be accomplished in either of two ways. Either by government supplement or by pooling of risks, so that the premium rate to the older person was no higher than it was to the normal, healthy person.

THE CHAIRMAN: In the pooling arrangement it would be all other beneficiaries, all other insured, who would contribute to bringing down the premium to those in the higher premium range?

MR. WILLS: That is correct, sir. The strong are carrying the weak sort of thing.

THE CHAIRMAN: If you go to the government supplement proposition that healthy class is not intended to support the weaker class at that stage?

MR. WILLS: In the final analysis perhaps it would, but it would not be so apparent.

THE CHAIRMAN: By taxation, in a roundabout way. In this proposal of government supplement, what do you recommend there? What do you foresee? Is that a supplement to the pool or to the individual?

MR. WILLS: I doubt, sir, whether we are competent, at least at this time, to make any specific recommendation in this area. I think perhaps you gentlemen are much more capable of determining this.

THE CHAIRMAN: No, you see, you run into a matter of principle there, on which the insurance fraternity apparently took a very strong stand yesterday







Wills

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3 morning. They are greatly opposed to a subsidy to the  
4 pool. It should go to the individual to help him pay  
5 his premium on an individual basis.

6 COMMISSIONER McCUTCHEON: They are  
7 like the railway companies. They don't like the subsi-  
8 dies to be described as subsidies to railways. They  
9 are subsidies to shippers.

10 MR. WILLS: We might perhaps feel that  
11 it might better go to the pool. We all have selfish  
12 interests, manufacturers and insurance people. It is  
13 difficult to analyze and assess the feelings, the depth  
14 of feeling.

15 THE CHAIRMAN: The idea of a subsidy  
16 to the pool isn't completely repugnant to you?

17 MR. WILLS: No, sir, I think we would  
18 prefer that, as an offhand decision.

19 COMMISSIONER McCUTCHEON: You are  
20 opposed to getting undue government influence in business,  
21 I get the idea from reading this brief. What do you  
22 think would be the result if the government contributed  
23 a large sum of money to a pool of this nature? Wouldn't  
24 the next move be that the government would say: "How  
25 is this pool operating? Are you fellows operating as  
26 efficiently as you should? Are you paying too high  
27 salaries?" and so on. Don't you immediately run into  
28 the political realm if you do that?

29 MR. WILLS: Quite possibly, sir. This  
30 is a continuing encroachment on what, at one time, was  
felt to be the realm of business management. I don't  
think I would care to answer that without further thought,



...they are greatly opposed to a subsidy to the  
pool. It would go to the individual to help him pay  
his premium on an individual basis.

COMMISSIONER McCUTCHEN: They are

like the railway companies. They don't like the subsi-  
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left to be the realm of business management. I don't

think I would care to answer that without further thought





Wills

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Mr. McCutcheon. Mr. Whitelaw?

MR. WHITE LAW: I would prefer not to elaborate.

THE CHAIRMAN: This idea of a re-insurance pool, or pooling arrangement, or supplement, is intended to take care of those who may find it difficult to buy insurance at a purchasable premium, or perhaps get it at all because of age, or pre-existing conditions. Then there is the third category that you mentioned. You mentioned three this morning. First, the ones who because of age; second, because of physical condition and we have been sort of lumping those two into one; and, three, a third group consisting of those of all ages who are unable to afford the cost of health insurance, and for that you recommend a special study.

What do you mean by a special study? Is it your thought that a special study will produce some result that will raise their economic status so that they will be able to pay premiums, or is it a study to provide a mechanism whereby they would be assisted in paying the premiums, or have the premiums paid for them?

MR. WILLS: I think, Mr. Justice Hall, the latter is what we are trying to express, perhaps obscurely. Some form of a means test, basically.

There is a further statistic that is a little appropriate on the 1,497 firms responding to the survey to which I referred. 1,117 of them paid more than 50% of the total cost of the surgical and medical premiums for their employees and dependents. What we





Mr. Johnson, Mr. Whitely:

MR. WHITELY: I would prefer not to

elaborate.

THE CHAIRMAN: This idea of a re-insurance

pool, or pooling arrangement, or supplement, is intended

to take care of those who may find it difficult to buy

insurance at a purchasable premium, or perhaps get it

at all because of age, or pre-existing conditions.

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because of age; second, because of physical condition

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and, third, a third group consisting of those of all

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some result that will raise their economic status so

that they will be able to pay premiums, or is it a

study to provide a mechanism whereby they would be

assisted in paying the premiums, or have the premiums

paid for them?

THE CHAIRMAN: I think, Mr. Johnson, that

the latter is what we are trying to express, perhaps

obscurely. Some form of a re-insurance, basically.

There is a further statistic that is a

little appropriate on the 1,447 firms responding to the

survey to which I referred. 1,111 of them paid some

then 54% of the total cost of the medical and hospital

premiums for their employees and dependents. What is



Wills

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are concerned about is the people who may be in the 6% unemployed ranks, and those who are chronically unemployable, who don't have the means to pay for health insurance. Some of them do have the means, but just as there is provision in the Old-Age Security Act to make payments prior to age 70 on need, some form of analysis might be made to determine those of the population who would be assisted medically.

THE CHAIRMAN: We have been discussing that group, giving them a sort of general name as those now receiving social aid.

MR. WILLS: Right.

THE CHAIRMAN: They have already been identified in order to qualify for social aid. Now, the basis of identification may differ from one point to another, but that is the group you are talking about?

MR. WILLS: Yes, sir.

THE CHAIRMAN: And you would visualize that for that group somebody would have to make a contribution for coverage?

MR. WILLS: Correct.

THE CHAIRMAN: And that somebody must be who? Anyone else but government, government, I mean, at some level; perhaps putting it more correctly, from tax funds?

MR. WILLS: We have said that we find it repugnant to feel that anybody must go without medical services for the reason that they are unable to pay for it. I don't know that we are too concerned basically as to who should pay, and how that payment should emanate.



are concerned about is the people who may be in the  
unemployed ranks, and those who are financially un-  
able, who don't have the means to pay for health  
insurance. Some of them do have the means, but just as  
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might be made to determine those of the population who  
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now receiving social aid.

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the basis of identification may differ from one point  
to another, but that is the group you are talking about?

MR. WILSON: Yes, sir.  
THE CHAIRMAN: And you would visualize  
that for that group somebody would have to make a contribu-  
tion for covered?

MR. WILSON: Correct.  
THE CHAIRMAN: And that somebody would  
be who? Would it be Government, Government, I mean,  
or would it be, perhaps, but it is more correctly, I mean,  
taxpayers?

MR. WILSON: I would say that we have  
it important to feel that anybody who is without health  
benefit for the reason that they are unable to pay  
it, I don't know how we are to be covered by  
the Government, and now that we have a new



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Wills

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We do say that it should emanate from  
some source.

THE CHAIRMAN: Are you in a position  
to make a recommendation of any source other than taxes?

MR. WILLS: I don't believe so.

MR. WHITELOW: I cannot think of any  
other source at the moment.

THE CHAIRMAN: So we may proceed on  
that basis, as what you are saying is tax support for  
that category?

MR. WILLS: We are resigned to the fact  
that this might be necessary, sir.

THE CHAIRMAN: That it might be neces-  
sary?

MR. WILLS: That it would be necessary.

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1. It is my duty to testify to the truth.

2. I am sworn to do so.

3. I am a member of the Federal Bureau of Investigation.

4. I am a member of the Federal Bureau of Investigation.

5. I am a member of the Federal Bureau of Investigation.

6. I am a member of the Federal Bureau of Investigation.

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12. I am a member of the Federal Bureau of Investigation.



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4 THE CHAIRMAN: I mean, there is a  
5 difference because I was wondering whether just in  
6 what situation you would see that it might not be  
7 necessary. We have that category in the community?

8 MR. WILLS: Correct.

9 THE CHAIRMAN: You take the very  
10 proper position that they should not go uncared for,  
11 therefore, it is a community's responsibility to care  
12 for them?

13 COMMISSIONER McCUTCHEON: And, as a  
14 matter of fact, a number of provinces have been taking  
15 that responsibility today, they are being cared for.

16 THE CHAIRMAN: I think it is accepted,  
17 by and large, one level or another of government they  
18 are being taken care of because they are identified as  
19 a social aid recipient.

20 You have a table on page 26 and I  
21 was wondering if you could tell me if these figures  
22 include what -- I will ask the question positively --  
23 do they include drugs and/or nursing?

24 MR. BARRETT: These do not include  
25 drugs or nursing.

26 COMMISSIONER McCUTCHEON: Special  
27 nursing?

28 MR. BARRETT: No, they do not include  
29 that. These are based on the figures from the Trans  
30 Canada Medical Plans and we used them simply to find  
some sort of average. As you realize, it is very  
difficult for us to arrive at any kind of cost of what



THE CHAIRMAN: I mean, there is a

difference because I was wondering whether that in

fact situation you would see that it might not be

necessarily. We have that category in the community?

MR. WILSON: Correct.

THE CHAIRMAN: You take the very

strong position that they should not go around for,

therefore, it is a community's responsibility to care

for them?

COMMISSIONER WILSON: And, as a

matter of fact, a number of provisions have been taken

that responsibility today, they are being carried for.

THE CHAIRMAN: I think it is accepted,

on and there, one level or another of government they

are being taken care of because they are identified as

a social aid recipient.

You have a table on page 16 and I

was wondering if you could tell me if those figures

include that -- I will ask the question collectively --

to the include drug abuse patients?

MR. WILSON: These do not include

drug abuse patients.

Thank you.

MR. WILSON: No, they do not include

that. These are listed on the figures on the Table

Table. Other figures and we need that simply to find

some sort of average. As you realize, it is very

difficult for us to arrive at any kind of sort of



1  
2  
3 these plans would be. We felt the Trans Canada Medical  
4 Plans break-down of costs gave us some sort of indication  
5 on which we could do some calculation. This includes  
6 physician services only.

7 COMMISSIONER BALTZAN: When you  
8 say physicians' services only, do you include also the  
9 necessary diagnostic things like x-ray and laboratory  
10 tests?

11 MR. BARRETT: That is right, sir.

12 COMMISSIONER BALTZAN: That is not  
13 exactly physicians' services?

14 MR. BARRETT: No, you are right there.

15 COMMISSIONER McCUTCHEON: These are  
16 the average costs of the plans that are sponsored by  
17 the medical profession in the various provinces?

18 MR. BARRETT: That is right.

19 COMMISSIONER McCUTCHEON: Or whatever  
20 benefits they provide?

21 MR. BARRETT: That is right.

22 THE CHAIRMAN: I notice, Mr. Wills,  
23 in your statement this morning you referred to the  
24 Unemployment Insurance, some reference to the Unemployment  
25 Insurance Fund and in the text of the brief I see this  
26 paragraph:

27 "The Unemployment Insurance Fund is  
28 "in such a serious condition that it  
29 "is considered necessary to conduct a  
30 "special enquiry to find the means  
"of restoring it to solvency. At the  
"same time it is being urged in some





in which we could do some calculation. This includes  
physician services only.

COMMISSIONER BARTON: When you  
say physician services only, do you include also the  
necessary diagnostic things like x-ray and laboratory  
tests?

MR. BARTON: That is right, sir.

COMMISSIONER BARTON: That is not

physician services?

MR. BARTON: No, you are right there.

COMMISSIONER BARTON: These are

the average costs of the plans that are sponsored by

the medical profession in the various provinces?

MR. BARTON: That is right.

COMMISSIONER BARTON: On whatever

benefits they provide?

MR. BARTON: That is right.

THE CHAIRMAN: I notice, Mr. White,

in your statement this morning you referred to the

unemployment insurance, and referred to the Interstate

Insurance Fund and in the rest of the bill I see this

as follows:

"The unemployment insurance fund is

"to be a special fund for the purpose of

"to be used for the purpose of

"to be used for the purpose of

"to be used for the purpose of

"to be used for the purpose of



Barrett

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"quarters that payments from this fund  
"should be increased significantly."

You did not carry that in your remarks  
this morning, in your summary this morning, and I was  
wondering if there was any significance to it or is this  
an interpolation that has nothing to do with health  
services?

MR. WILLS: I do not think it has  
anything to do with health services as such. This as  
you said is an illustration to point out the increasing  
demands on costs that manufacturers are faced with. It  
is probable or even possible that the government  
insurance fund which is not worked on an actuarially  
sound basis must be increased. If payments are to be  
increased on the outside, payments must be increased  
on the inside.

THE CHAIRMAN: Are you making any  
suggestion that the government insurance fund should  
be used as an adjunct or addition or some component  
proposition to health services?

MR. WILLS: In no way at all, sir.

COMMISSIONER McCUTCHEON: I suppose  
it is fair to say that to the extent that increased  
demands should be required from industry for the  
unemployment insurance fund, however, to provide the  
present benefits or provide greater benefits, if that  
should happen it would leave that much less that industry  
would have to contribute to national health care?

MR. WILLS: I think that is the point,  
it is all part of the total welfare cost. We say we do



"quarters that payments from this fund  
"should be increased substantially."  
You did not carry that in your remarks

this morning, in your summary this morning, and I was  
wondering if there was any significance to it or is this  
an interpolation that has nothing to do with health  
services?

MR. WILLS: I do not think it has  
anything to do with health services as such, I think  
you said is an illustration to point out the increasing  
burden on costs that businesses are faced with. It  
is possible on over possible that the government  
insurance fund which is not worked on an actuarially  
sound basis must be increased. If payments are to be  
increased on the outside, payments must be increased  
on the inside.

THE CHAIRMAN: Are you making any  
suggestion that the government insurance fund should  
be used as an adjunct or addition or some component  
proposition to health services?

MR. WILLS: In a very general way,  
I suppose  
it is fair to say that to the extent that increased  
payments should be required from industry for the  
unemployment insurance fund, however, to provide that  
payments be made in order to meet the needs of the  
unemployed, it would leave the fund in a position  
which would have to contribute to national health care.

MR. WILLS: I think that is the way  
it is part of the total welfare cost. The way we do





Wills

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3 not believe any segment can be taken in isolation that  
4 it is the total effect that concerns us.

5 COMMISSIONER FIRESTONE: I understand,  
6 Mr. Wills, that we are to address questions to you but  
7 please feel free to refer to any of your associates if  
8 you so wish.

9 Mr. Wills, if we may turn to paragraph  
10 8 on page 3 in which you point out that one of the  
11 very important reasons for the great increase in the  
12 coverage in voluntary health insurance plans in Canada  
13 has been the adoption as part of an employee benefit  
14 programs for a large number of employers in various  
15 industries and you are good enough to quote some figures  
16 based on the survey which you have undertaken in 1959.  
17 What I would like to establish with a little help from  
18 you is to see whether we can arrive at a very rough  
19 approximation of the wage earners that are now covered  
20 by these various plans and see whether further progress  
21 in these voluntary plans, that process of evolution  
22 which you have described, might achieve the Canadian  
23 objective of fairly wide coverage for Canadian people  
24 using the existing system with some improvements as  
25 you have suggested. I am wondering whether we can  
26 follow the following approach: We know that there are  
27 approximately two-thirds of our working population  
28 are wage earners, in fact, in the Ontario Hospitalization  
29 scheme about 65% of the premiums are covered by the  
30 scheme that covers contributions by employers employing  
a given number of employees. It is roughly about  
two-thirds across the country. I might say that these





not believe any segment can be taken in isolation that  
it is the total effect that concerns us.

COMMISSIONER WINDSOR: I understand,

Mr. Willis, that we are to address questions to you but  
please feel free to refer to any of your associates if  
you so wish.

Mr. Willis, if we may turn to paragraph

1 on page 1 in which you point out that one of the  
very important reasons for the great increase in the  
coverage in voluntary health insurance plans in Canada  
has been the adoption as part of an employee benefit  
program for a large number of employees in various  
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What I would like to establish with a little help from  
you is to see whether we can arrive at a very rough  
approximation of the wage earners that are now covered  
by these various plans and see whether further progress  
in these voluntary plans, that process of evolution  
which you have described, might achieve the Canadian  
objective of fairly wide coverage for Canadian people  
using the existing system with some improvements as  
you have suggested. I am wondering whether we can  
follow the following approach. We know that there are  
approximately 4 million of our working population  
and wage earners, in fact, in the Ontario Hospitalization  
scheme about 65% of the payments are covered by the  
scheme that covers contributions by employers and  
a large number of employees. It is roughly about  
10-12% of the country. I might say that these



Wills

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3 are premiums solely used for the purpose of illustrating  
4 a problem and not as an exact measurement. We are  
5 going to rely on our own research staff and others to  
6 work out an adequate measurement but just for the purpose  
7 of discussion we can start out with the basic premise  
8 that about two-thirds of our working population are  
9 wage earners and if we further assume these wage  
10 earners have similar sized families like the rest of  
11 the people in Canada it would mean that we are talking  
12 about 12 million people, two-thirds of 18 million that  
13 are wage earners, and their dependents.

14 MR. WILLS: Right.

15 COMMISSIONER FIRESTONE: Taking these  
16 12 million people as a basis and looking at the figure  
17 which you have in footnote 1 on page 3 we find that  
18 you refer here to about 7,365,000 people being covered  
19 by insurance group plans. Now, some of these people  
20 would be non-wage earners and their dependents which,  
21 as you say in your text, the overwhelming majority would  
22 be wage earners and their families allowing for a little  
23 excess of non-wage earners, it includes all non-wage  
24 earners in this group, one arrives out of the approxima-  
25 tion of one-half or a little more than one-half of  
26 wage earners and their dependents presently being  
27 covered by insurance group plans of the type which you  
28 described in footnote 1, page 3. Would you agree with  
29 this basic premise?

30 MR. WILLS: I think so, yes sir.

COMMISSIONER McCUTCHEON: Subject to  
the fact it could and will be confirmed?



are... for the purpose of illustrating  
a... and not as an... We are  
going to... on our... and others to  
work out an... but just for the purpose  
of... we start out with a...  
that about two-thirds of our working population are  
wage earners and if we... these have  
... have similar... like the rest of  
the... in Canada it would... that we are talking  
about 15 million people, two-thirds of 18 million that  
are wage earners, and their dependents.

Mr. Miller: ...

COMMISSIONER: ... Taking these  
15 million people as a basis and looking at the figure  
which you have in footnote 1 on page 3 we find that  
you refer here to about 7,800,000 people being covered  
by... group plans. Now, some of these people  
would be non-wage earners and their dependents which,  
as you see in your text, the overwhelming majority would  
be wage earners and their dependents. ... little  
excess of non-wage earners, if included all non-wage  
earners in this group, one arrives out of the group  
than on one-half or a little more than one-half of  
wage earners and their dependents... being  
covered by... group plans or the two which you  
mentioned in footnote 1, ... would you agree with  
this basic...?

... set to  
the... it...





Wills

10436

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4 COMMISSIONER FIRESTONE: Subject to  
5 further research that will either confirm it or not --  
6 the figure may turn out to be 55% or whatever the  
7 research people come up with or it could be more or  
8 less.

9 COMMISSIONER McCUTCHEON: Do you  
10 include Mr. Wills as a wage earner? These Ontario  
11 employment plans cover the boss and everybody else, the  
12 hospital insurance, the boss has to cover himself?

13 COMMISSIONER FIRESTONE: We were going  
14 on the premise of wage earners and we were going on the  
15 premise of wage earners as a proportion of total gainfully  
16 employed. These figures are taken from the 1961 census  
17 and our research people will see that they are not  
18 based on the Ontario Hospitalization plan. I have used  
19 that as an example and it will be based on the census  
20 and other information available. We can see that  
21 perhaps half or a little better of wage earners and  
22 their families are covered by these employee benefit  
23 programs that you have been indicating to us in paragraph  
24 8. The question I would like to put to you, could you  
25 give us some reason why another half of Canada's wage  
26 earning population are not covered?

27 MR. BARRETT: I think the way we would  
28 look at it is this: If you notice our table on page  
29 21 we had that to illustrate the growth of these plans.  
30 We also recognize and we, unfortunately, have not been  
able to arrive at any conclusion, that there is a  
percentage of the population who would not be covered  
for various reasons. There are a good many people who do





5-11-25

29



Barrett

10437

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4 not require coverage such as the armed forces, that is  
5 one class, and some religious groups who would not  
6 accept coverage if it were offered. We were looking at  
7 it more from the point of view of total population. We  
8 feel that these things have a long way to go yet but  
9 they are showing evidence that they are continuing to  
10 grow and we feel they should be encouraged because they  
11 are doing a good job.

12 COMMISSIONER FIRESTONE: I think this  
13 is a laudable objection. I was going to concentrate  
14 on the areas with which you are more familiar and this  
15 is the employee benefit program because these are the  
16 segments that you in your own industries are working  
17 with, dealing with unions and negotiating such programs.  
18 I would like to get some advice from you as to what  
19 are the difficulties in this group of wage earners,  
20 people employed in large firms or in small firms to  
21 extend that coverage close to an additional half? What  
22 are the difficulties? If we knew a little bit more  
23 about the difficulties perhaps we could remove some of  
24 the difficulties from this process of evolution that  
25 you speak about because the payment for a national  
26 health plan would be less pressing if all these people  
27 were covered and as long as they are covered and we  
28 would like to get some advice as to what some of the  
29 difficulties are in extending this employee benefit  
30 program to another half of the working population.



not require coverage such as the medical, dental, life insurance, and some other things which would not be covered if it were offered. He was looking at it from the point of view of total protection. He felt that these things have a long way to go yet but they are showing evidence that they are continuing to grow and we feel they should be encouraged because they are doing a good job.

COMMISSIONER FURNITURE: I think this

is a laudable objection. I was going to concentrate on the areas with which you are more familiar and this is the employee benefit program because that is the area that you in your own industries are working with, dealing with unions and negotiating such programs. I would like to get some advice from you as to what are the difficulties in this group of ways whereby people employed in large firms or in small firms to extend that coverage close to an additional 100 million people who are the difficulties. If we know a little bit more about the difficulties we could remove some of the difficulties from the process of evolution that you speak about because the payment for a national health plan would be paid by all these people who are covered and as long as they are covered and we would like to get some advice as to what some of the difficulties are in extending this employee benefit program to another half of the working population.





Wills 10438

COMMISSIONER FIRESTONE: May I say one other thing. Some of these questions may be rather difficult to answer and we are sincerely interested in your own considered views and, therefore, if you, Mr. Whitelaw and your associate Mr. Wills or anyone else feel you want to consider these questions and give us your considered opinion subsequently, in written form or any other form, we will be very happy to have the answer. We are interested in your views, not in a snap answer, if you are not quite familiar or you feel that you would not want to commit yourself without careful study of the question.

MR. WILLS: Thank you, Dr. Firestone. I think that in answering, or attempting to answer the point that you raised, opinion will have to be a large part of the answer.

In speaking for the manufacturing operations of the country, which if we do have any qualifications it would be in this area, the difficulty in the extension of company-sponsored health plans, the reason the progress may in the future be slower than the rate of it in the past, which I believe will develop, is the number of small companies with 15 employees or less, or a few employees who are operating marginally who can't really afford some of the nicer social measures which large companies, who have an established base can pay, so I think that a great many of those without coverage are included in this small employment group.

I would suggest also, aside from the manufacturing areas, that many service companies, laundries,





1970

COMMISSION ON THE STATUS OF WOMEN

one other thing. Some of these questions may be raised  
difficult to answer and we are sincerely interested in  
your own considered views and, therefore, if you, Mr.  
Whitlow and your associates Mr. Williams and Mr. Williams  
feel you want to consider these questions and give us  
your considered opinion, in written form, in written form  
in any other form, we will be very happy to have the  
answer. We are interested in your views, not in a ready  
answer, if you are not quite certain or you feel that  
you would not want to commit yourself without careful  
study of the question.

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point that you raised, opinion will have to be a large

In speaking of the Commission

operation of the country, which it is to have any  
political action it would be in this area, in which  
in the extension of social responsibility of health care.

the reason the progress may in the future be slower than  
the rate of it in the past, which I believe will develop  
is the number of small companies with 10 employees or  
less, or a few employees who are operating especially  
who can't really afford a lot of the most social research  
with some companies, who have a determined base can  
be a little more a great part of those without  
coverage are included in this study, a movement project.  
I would suggest also, aside from the

transferring some, that more service companies, including



Wills 10439

dry-cleaners, pressers, bread deliverers, etcetera, where there is a greater labour turnover than there is in manufacturing are areas in which some of the social measures have not yet reached the maturity that they have in manufacturing.

If there is to be a marked increase in this coverage, I think we could expect it might come from some of those areas.

COMMISSIONER FIRESTONE: That is a very fair answer. What you have been saying to us is that larger companies, well-organized companies who have satisfactory management-labour relations have already moved into the plan and the difficulty that the Nation faces, and that the industry faces, is how to extend these reasonable and successful policies to the rest of the industry.

You have pointed out one of the difficulties we face; that in the group still to be covered are a large number of firms employing a small number of employees. That is one of the problems.

The question now arises what can one do to facilitate the smaller firms to extend coverage to their employees? Have you any suggestions? It may not be as important in manufacturing sectors, as you were saying, because the bulk of your employment is provided by large companies, but there are still some small-size manufacturing enterprises, and it is more important in the service sector which you mentioned. You are quite right. What can be done?

MR. WHITELOW: I would say, Doctor,



Wills

There is a greater labor turnover than there is in manufacturing areas in which some of the social resources have not yet reached the maturity that they have in manufacturing.

There is to be a marked increase in this coverage, I think we could expect it might come from some of those areas.

COMMISSIONER WILSON: That is a

very fair answer. What you have been saying to us is that large companies, well-organized companies who have satisfactory management-labor relations have already moved into the plan and the difficulty that the labor faces, and that the industry faces, is how to extend these reasonable and successful policies to the rest of the industry.

You have pointed out one of the difficulties we face; that in the group still to be covered and a large number of firms employing a small number of employees. This is one of the problems.

The question now arises, what can be done to facilitate the problem of extending coverage to this employees? Have you any suggestions? It may not be as important in manufacturing sectors, as you were saying, because the bulk of your employment is now taken by large companies, but there are still some small-scale firms that are an employer, and it is not so important in the same way as manufacturing. You are not a right, what can be done. I would like to know.





Whitelaw 10440

that we would like to take that question under advisement and give it the attention and consideration that it obviously merits. We would like to deliberate that in Committee and furnish you with the reply in written form.

COMMISSIONER FIRESTONE: Well, I appreciate that, Mr. Whitelaw. May I explain the question, if you are going to consider it, to give us a more rounded point of view that would set out, first, your own judgment as to some of the difficulties that are being faced by firms that do not provide the coverage, as the companies have not been able to. You have given us some reasons and you may think of some others. If we can have a rounded reply the way to deal with the problem, the reason for the problem, and what can be done about the voluntary employer-employee plans that we have been talking about so we could get a more rounded and full reply, so that we can see the problem in perspective and also have your ideas on what can be done to solve the problem.

MR. WHITELAW: We would be happy to attack it in that fashion.

COMMISSIONER FIRESTONE: Thank you. May I now turn to Paragraph 11, Page 5, in which you refer, Mr. Wills, to co-insurance principle which is adopted in most of your plans and you say usually something like 20% of bills are expected to be paid by those covered. From your experience has this co-insurance arrangement of the order of 20%, more or less, been effective enough to curb misuse of the insurance arrangements





that we would like to take that question under discussion  
and give it the attention and consideration that it  
deserves. We would like to deliberate this in  
a more rounded point of view that would set out, first,

second, third, fourth, fifth, sixth, seventh, eighth, ninth, tenth, eleventh, twelfth, thirteenth, fourteenth, fifteenth, sixteenth, seventeenth, eighteenth, nineteenth, twentieth, twenty-first, twenty-second, twenty-third, twenty-fourth, twenty-fifth, twenty-sixth, twenty-seventh, twenty-eighth, twenty-ninth, thirtieth, thirty-first, thirty-second, thirty-third, thirty-fourth, thirty-fifth, thirty-sixth, thirty-seventh, thirty-eighth, thirty-ninth, fortieth, forty-first, forty-second, forty-third, forty-fourth, forty-fifth, forty-sixth, forty-seventh, forty-eighth, forty-ninth, fiftieth, fifty-first, fifty-second, fifty-third, fifty-fourth, fifty-fifth, fifty-sixth, fifty-seventh, fifty-eighth, fifty-ninth, sixtieth, sixty-first, sixty-second, sixty-third, sixty-fourth, sixty-fifth, sixty-sixth, sixty-seventh, sixty-eighth, sixty-ninth, seventieth, seventy-first, seventy-second, seventy-third, seventy-fourth, seventy-fifth, seventy-sixth, seventy-seventh, seventy-eighth, seventy-ninth, eightieth, eighty-first, eighty-second, eighty-third, eighty-fourth, eighty-fifth, eighty-sixth, eighty-seventh, eighty-eighth, eighty-ninth, ninetieth, ninety-first, ninety-second, ninety-third, ninety-fourth, ninety-fifth, ninety-sixth, ninety-seventh, ninety-eighth, ninety-ninth, one hundred, one hundred and one, one hundred and two, one hundred and three, one hundred and four, one hundred and five, one hundred and six, one hundred and seven, one hundred and eight, one hundred and nine, one hundred and ten, one hundred and eleven, one hundred and twelve, one hundred and thirteen, one hundred and fourteen, one hundred and fifteen, one hundred and sixteen, one hundred and seventeen, one hundred and eighteen, one hundred and nineteen, one hundred and twenty, one hundred and twenty-one, one hundred and twenty-two, one hundred and twenty-three, one hundred and twenty-four, one hundred and twenty-five, one hundred and twenty-six, one hundred and twenty-seven, one hundred and twenty-eight, one hundred and twenty-nine, one hundred and thirty, one hundred and thirty-one, one hundred and thirty-two, one hundred and thirty-three, one hundred and thirty-four, one hundred and thirty-five, one hundred and thirty-six, one hundred and thirty-seven, one hundred and thirty-eight, one hundred and thirty-nine, one hundred and forty, one hundred and forty-one, one hundred and forty-two, one hundred and forty-three, one hundred and forty-four, one hundred and forty-five, one hundred and forty-six, one hundred and forty-seven, one hundred and forty-eight, one hundred and forty-nine, one hundred and fifty, one hundred and fifty-one, one hundred and fifty-two, one hundred and fifty-three, one hundred and fifty-four, one hundred and fifty-five, one hundred and fifty-six, one hundred and fifty-seven, one hundred and fifty-eight, one hundred and fifty-nine, one hundred and sixty, one hundred and sixty-one, one hundred and sixty-two, one hundred and sixty-three, one hundred and sixty-four, one hundred and sixty-five, one hundred and sixty-six, one hundred and sixty-seven, one hundred and sixty-eight, one hundred and sixty-nine, one hundred and seventy, one hundred and seventy-one, one hundred and seventy-two, one hundred and seventy-three, one hundred and seventy-four, one hundred and seventy-five, one hundred and seventy-six, one hundred and seventy-seven, one hundred and seventy-eight, one hundred and seventy-nine, one hundred and eighty, one hundred and eighty-one, one hundred and eighty-two, one hundred and eighty-three, one hundred and eighty-four, one hundred and eighty-five, one hundred and eighty-six, one hundred and eighty-seven, one hundred and eighty-eight, one hundred and eighty-nine, one hundred and ninety, one hundred and ninety-one, one hundred and ninety-two, one hundred and ninety-three, one hundred and ninety-four, one hundred and ninety-five, one hundred and ninety-six, one hundred and ninety-seven, one hundred and ninety-eight, one hundred and ninety-nine, two hundred.

and also have your ideas on what can be done to  
solve the problem.  
We would be happy to  
discuss it in that fashion.  
Thank you.  
I now turn to paragraph 11, Page 5, in which you  
state, in effect, to coordinate principles which is  
a part of your plan and you say that it is  
a part of the plan and expected to be paid by those  
concerned. I am not sure that this is a  
part of the plan, but I am not sure.

I am not sure that this is a part of the plan, but I am not sure.



Wills 10441

as you have developed it in industry?

MR. WILLS: May I ask Mr. Hallsworth his experience in that area?

MR. HALLSWORTH: I am really not competent to speak too well on this. In the automotive industry we have hospital, medical phases of the insurance plan. We have the prepaid plan, Windsor Medical type, Physician Services which do not have a co-insurance aspect.

We have adopted this structure for more senior people: And this is an expanded major medical type insurance where there is definitely a co-insurance feature with special nursing, special drugs, special attention.

There is a waiting period and X number of dollars before the claim comes in. This tends to pull the premium cost of this type of insurance down to a reasonable level.

COMMISSIONER FIRESTONE: As I understand it, your employees receive 100% medical care coverage, not 80%?

: MR. HALLSWORTH: That is right.

COMMISSIONER FIRESTONE: Can we have some experience from somebody that is using the 20% co-insurance feature?

MR. MARRS: We have a comprehensive insurance plan in the Canadian General Electric Company which does provide a deductible feature and then a partial payment. In the case of hospitals and surgical we pay 85%; anything else, drugs, any other things, we



as you have developed it in it last?

his experience in that area?

MR. MILLER: I am really not

competent to speak too well on this. In the automobile

industry we have hospital, medical phases of the insurance

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aspect.

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more medical aspects. And this is an expanded major medical

type insurance where there is actually a co-insurance

feature with special nursing, special drugs, special

there is a waiting period and Y factor

of dollars before the claim comes in. This tends to limit

the premium cost of this type of insurance down to a

reasonable level.

COMMISSIONER: I think that is important

it, your employees receive 100 percent cost coverage,

not stop

MR. MILLER: That is right.

some experience from somebody that is using the 20 co-

insurance feature?

MR. MILLER: We have a comprehensive

insurance plan in the Canadian General Insurance Company

which does provide a medical insurance feature and then

partial coverage. In the case of hospital and surgical

coverage, the cost of hospital and surgical





Marrs 10442

1  
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4 pay 75%. We do feel that we have been able to keep the  
5 cost down and by that have been able to apply much higher  
6 benefits to our employees on the more serious cases. We  
7 also believe the reason for the deductible and the partial  
8 payment is that our employees can afford to pay the  
9 small amount required for that and so we are able to  
10 provide much higher coverage for the catastrophic cases.

11 COMMISSIONER McCUTCHEON: Is your  
12 scheme the result of collective bargaining?

13 MR. MARRS : It was offered with the  
14 Union's concurrence, that is right. I am not sure whether  
15 the Union first proposed it or the company proposed it to  
16 the Union.

17 COMMISSIONER McCUTCHEON: It is an  
18 item for bargaining?

19 MR. MARRS: Yes.

20 COMMISSIONER McCUTCHEON: So that we  
21 can assume at this stage the Union is satisfied?

22 MR. MARRS: Yes. It would be interesting  
23 to note that at the time we offered it, we offered two  
24 plans. A basic plan which covered hospital and surgical  
25 coverage and then a corridor and then extraordinary medical  
26 expense type.

27 When we offered this plan, we presented  
28 the plans either on an expanded basic or the comprehensive  
29 and we had about 80% of our employees prefer the compre-  
30 hensive.

THE CHAIRMAN: They are able to get  
the wider coverage at the top end a little less at the  
lower end for the same money?





1944

pay 75% is the fact that we have been able to keep the cost down and that have been able to supply much larger benefits to our employees on the more serious cases. We also believe the reason for the deductible and the partial payment is that our employees can afford to pay the small amount required for that and so we are able to provide much higher coverage for the catastrophic cases.

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W. HARRIS: Yes, it would be interesting

to note that at the time we offered it we offered two

plans. A basic plan which covered hospital and surgical coverage and then a secondary and then extraordinary medical expense type.

When we offered this plan, we presented the plans either on an extended basis or the comprehensive and we had about 80% of our employees, rather the comprehensive.

W. HARRIS: They are able to pay

the higher coverage at the top end a little less for the

lower end for the same money.



Marrs 10443

MR. MARRS: That is right. They pay the first small portion on the basic. The fellow who has to have his child's tonsils out gets the full payment. Still, the majority of our employees prefer the comprehensive. I mentioned 80% at the time. The figure now is much larger in favour of the comprehensive. There has been a couple of opportunities to exchange.

COMMISSONER FIRESTONE: As I understand it, sir, you have approximately 15% to 25% co-insurance on the part of your employees?

MR. MARRS: That is right.

COMMISSIONER FIRESTONE: Now, has your experience been in this co-insurance arrangement, 15%, 25% that has prevented misuse of the plan?

MR. MARRS: To a great extent we believe that. We have had no direct comparison.

COMMISSIONER FIRESTONE: But you have had no complaints of misuse of any form from any source?

MR. MARRS: Other than a couple of cases of attempted fraud, sir.

COMMISSIONER FIRESTONE: Taking the odd exceptions of a couple of cases, or a few more, I don't know. Except for these, sir, special cases there have been no complaints about the system? You have found it to work effectively?

MR. MARRS: That is right. It needs, of course, taking a look at. What we did, as a matter of fact, was have sessions at various places and explained it to doctors and druggists, and so on, what the plan was for. How it would work and how they could assist and how



Q. Now, what is the first thing that you remember?

A. The first thing I remember is that I was in the kitchen and I was looking at the clock and I was thinking that it was about 10:30 and I was thinking that I should go to work. I was thinking that I should go to work and I was thinking that I should go to work. I was thinking that I should go to work and I was thinking that I should go to work.

Q. Now, you have approximately 100 to 150 co-employees?

A. Yes, approximately 100 to 150 co-employees.

Q. Now, what is the first thing that you remember?

A. The first thing I remember is that I was in the kitchen and I was looking at the clock and I was thinking that it was about 10:30 and I was thinking that I should go to work.

Q. Now, you have been in this co-employment arrangement?

A. Yes, I have been in this co-employment arrangement.

Q. Now, what is the first thing that you remember?

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Marrs 10444

it would assist them obtaining payment of bills.

COMMISSIONER FIRESTONE: What do your employees pay on an average in this plan?

MR. MARRS: It is a percentage basis. The hospital before the Ontario Hospital they were paying nine-tenths of one percent of their amount and 2% for the dependents.

This is a complicated figure, sir. In the case of an employee includes life insurance on twice-annual earnings. Accidental death on another time annual earnings. Weekly sickness, accident, up to \$70.00 a week based on half pay, as well as the other medical.

Probably 2% on the basis of about two and a half dependents is a truer figure, because we expect the employees to pay the dependent cost of claims. We provide, in addition to the service in the company, we undertake to pay the administrative cost of the insurance. So in answer to your question, the 2% of earnings covering an average of about three people, I think would be a truer figure.

COMMISSIONER FIRESTONE: What would that mean on an average per month?

MR. MARRS: Our average earnings are about 45, 4800 per year, so 2% ---

COMMISSIONER FIRESTONE: That would be \$96.00 per year, which would work out \$8.00 a month?

MR. MARRS: Yes.

COMMISSIONER FIRESTONE: Now, that \$8.00 covers medical?

MR. MARRS: Covers hospital in the





It is the policy of the Board to require that all

employees be given a written statement of their

rights and duties at the time of their hiring.

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employees be given a written statement of their rights and duties at the time of their hiring.

This is a written statement of their rights and duties.

In the case of an employee, the Board has issued an order requiring the employer to provide a written statement of the employee's rights and duties at the time of their hiring. This order is issued to all employers who are required to provide a written statement of their rights and duties at the time of their hiring.

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Marrs 10445

public ward. Now, we made a deduction from that figure. Let us assume that that figure covers the full cost of hospital before Ontario Hospital took over the major part of it. It also covers surgery, doctor bills at home, anywhere, it covers X-rays, includes nursing, registered nurses and drugs and even such things as iron lungs.

COMMISSIONER FIRESTONE: Out of the \$8.00 something has to be assigned to hospital care between public ward and semi-private? \$1.00 or \$2.00?

MR. MARRS: The arrangement we made when the Ontario Hospital Plan was instituted was we determined from the insurance company what they estimated the break-down was for that particular part so that the 2% is reduced by 87¢ per week to cover that part.

COMMISSIONER FIRESTONE: Therefore, if you wanted just the figure to cover medical care services, nursing, etcetera, drugs, excluding the hospital, one should take off that figure?

MR. MARRS: That is right.

COMMISSIONER FIRESTONE: It would then be about \$7.00?

MR. MARRS: The 87¢ is on a weekly basis.

COMMISSIONER FIRESTONE: So you would have to take off ---

THE CHAIRMAN: Approximately \$40.00.

COMMISSIONER FIRESTONE: You would be left with about \$5.00? \$4.50 for medical care service?

MR. MARRS: That is right.



and the same. Now, we have a deduction from that figure.  
 Let us assume that that figure covers the full cost of  
 hospital bill (which is not the case) over the major  
 part of it. It also covers surgery, doctor bills, at  
 home, anywhere, it covers X-rays, includes nursing,  
 registered nurses and diets and even such things as iron  
 lungs.

COMMISSIONER FLETCHER: Out of the

\$100 some thing has to be assigned to hospital care  
 between public and semi-private? Of 10 or \$2.00?  
 MR. HARRIS: The arrangement we made

when the public hospital plan was instituted was we  
 determined from the insurance company what they estimated  
 the break-down was for that particular part so that the  
 25 is reduced by 15 per cent to cover that part.

You wanted just the figure to cover medical care services,  
 nursing, pharmacy, diets, excluding the hospital, and  
 should the old figure?

COMMISSIONER FLETCHER: It would not.

MR. HARRIS: The 60 is on a weekly

basis.

COMMISSIONER FLETCHER: He was wrong.

Now to take old --

COMMISSIONER FLETCHER: It is not correct.

Just with about \$4.00 out of the medical care services  
 that is right.



ANGUS. STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Marrs 10446

COMMISSIONER FIRESTONE: What are your company's contributions to the payment?

MR. MARRS: We have always on these figures, on talking about dependents, the company in order not to discriminate between employees with dependents and employees without dependents makes a contribution to dependent coverage approximately equal to the amount of the administrative cost of the insurance. The company contributed about 73% last year of the cost of this total insurance coverage for employees.

COMMISSIONER FIRESTONE: In other words, if the employee contributes \$4.50 the company contributes \$3.00. Is that right?

MR. MARRS: No, sir, the company only contributes the administrative expenses of that. I would be glad to break these figures down for you and present them to you subsequently.





10-15-45

COMMISSIONER: I am very

company's contribution to the benefit?

MR. MARSH: We have always on these

figures, on talking about dependents, the company in

not to discriminate between employees with dependents and

employees without dependents makes a contribution to

dependent coverage approximately equal to the amount of

the administrative cost of the insurance. The company

contributed about 7% last year of the cost of this total

insurance coverage for employees.

COMMISSIONER: In other

words, if the employee contributes \$4.50 the company

contributes \$5.00. Is that right?

MR. MARSH: No, sir, the company only

contributes the administrative expenses of that. I would

be glad to break these figures down for you and present

them to you subsequently.



Hallsworth

10447

COMMISSIONER FIRESTONE: I think that would be very helpful. What we are trying to arrive at, what is the present position as far as the employee-employer benefit plans are concerned which you have discussed in this paragraph A; what do employees contribute, what do employers contribute?

If we could get that information we would appreciate it.

MR. HALLSWORTH: Dr. Firestone, if I may, I think you will find there is a wide variety of plans and percentage payments from one industry to another, particularly where health and medical benefits become embedded as part of the collective bargaining relationship. These things are not bargained for in isolation. There is the matter of wages, pensions, health, accident and sickness benefits and all of the so-called fringe benefits that arise in an employee-employer relationship.

For instance, you will find in the automobile business, in many places, the larger industries, these things have been part of the bargaining arrangement for many years and the employer pays the full cost. In other industries, there is a different proportion of the cost, but perhaps more emphasis on pensions or wages or some other element of the relationship between the parties.

COMMISSIONER FIRESTONE: You see, sir, if we could obtain information as to how much is presently being paid by employees and by employers of the total cost of medical care programs, it will show us





Hallsworth

10448

the area that is not covered. While I admit there are different plans in existence, there is certain basic information. I accept your undertaking, sir, and it will be very helpful if such information can be made available to us. I am sure our research people will go into great detail in this field.

May I now turn to paragraph 20 on page 8, Mr. Wills, in which you refer to the problem of the indigent who cannot afford to pay health insurance. I think in answer to a question by the Chairman you elaborated that group, and as I understand it, you talked in this category of the social welfare cases which are accepted in clearly defined groups of people.

I am just wondering whether, when you speak of some extension of benefits to people that cannot afford to pay for such benefits, you only have in mind the indigent as defined as welfare cases or whether you would also include the group which is called the medically indigent? They are people that may be in receipt of incomes, but their income level may be rather low, they may have a large number of families and they may find it difficult to carry the premiums that are required to obtain this sort of health service we are talking about.

There may be another group, the unemployed people, who could look after themselves quite nicely when they were employed, but they lose their job and they live on unemployment insurance, unemployment assistance, not quite enough to cover all their needs, and therefore, their problem is also one of obtaining medical





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E. Mr. White, in which you refer to the group, of the  
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Wills

10449

services for which they are not in a position to pay.

Would I be right in assuming when you talk of the indigents in paragraph 20 on page 8, do you have in mind both the indigent and the medically indigent as I have just defined them?

MR. WILLS: Yes, sir.

COMMISSIONER FIRESTONE: Thank you very much, sir. May I now turn to page 13? I would like to congratulate you first for the recommendation contained in paragraph 28. You say, and I quote:

"The total picture must be studied and any recommendations that are advanced must be based on the total effect of all social welfare costs on the economy."

I think that is a reasonable and statesmanlike approach to take. We will bear in mind your recommendation on this point.

In paragraph 29 you say that:

"Any national scheme of health insurance would undoubtedly be subject to a great many abuses which are very difficult to control,"

and you elaborate these in subsequent paragraphs with particular reference to the British experience.

I wonder whether I could explore with you a little the kind of abuses which you have in mind or the increases in cost that would be difficult to control. As I see it, sir, there are four factors that might contribute to increased cost under a national



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talk of the indigents in paragraph 10 on page 4, do  
you have in mind both the indigent and the medically  
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COMMISSIONER FIRESTONE: Thank you very

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Wills

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health insurance plan; four major factors.

There may be others, but if I may just list the four and get your comments on each of these. The first one would be mis-use. I am wondering if such a plan adopted a principle of co-insurance, 15 to 25%, that sort of thing, as has been mentioned, whether you would feel this problem of mis-use would be as serious as you had anticipated because, after all, that is the way it is already working now?

MR. WILLS: I think with the element of co-insurance a person who tends to be over-concerned with his health would tend to restrict his visits to the practitioner. We all have sensitive areas.

COMMISSIONER FIRESTONE: If I understand you correctly, you feel the introduction of a co-insurance provision would reduce the mis-use to controllable proportions?

MR. WILLS: Yes, sir.

COMMISSIONER FIRESTONE: The second reason for rising costs would be inefficiency of operation because, presumably, under a national scheme of health insurance, government would administer and there is a view held in some circles, anything administered under government increases the cost of administration.

If the provincial governments were to introduce a plan and it would go to the medically-sponsored non-profit organizations to administer the plan, whether P.S.I. in Ontario or M.S.A. or M.S.I. in Manitoba, would you feel that these rising costs would be as serious a matter, if you turned it over to people





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Perry

10451

who are already in the business and doing it efficiently?

MR.PERRY: I think we have found, Dr. Firestone, a great number of people added in the provincial government hospital plan already. They have built a monument on Yonge Street, a building to house them. Speaking from some experience, administration of any welfare plan is considerably more expensive than with a competitive situation where it is possible to reduce substantially the administration in what might be termed businesslike concerns.

I would think your bureaucracy would tend to grow. I would suggest it perhaps would be more expensive than streamlined business concerns who are fighting tooth and nail for business that have to reduce their admin. loading costs directly when bargained with by the employer directly.

COMMISSIONER FIRESTONE: Would you feel if the administration is carried on by those medically-sponsored organizations your increase in costs would be as large as if it was government-administered or would there be a saving, if you were offering it to people in the business with experience?

MR. PERRY: You are going to a chosen instrument and you are taking out the competition, if I understand your question.

COMMISSIONER FIRESTONE: You understand the question correctly. This has been suggested to us in one particular province, that the province might turn to a voluntary organization to do the administration because these people know the business and have been in



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Perry

10452

the business. I am trying to discover whether such an approach would take care of some of the fears expressed.

COMMISSIONER McCUTCHEON: I think what Mr. Perry really said was it might not be quite as bad as if the Government was administering it, but any monopoly tends to produce higher costs.

MR. WILLS: Correct.

COMMISSIONER FIRESTONE: Well, of course, I am not in a position to question my fellow Commissioner otherwise...

COMMISSIONER McCUTCHEON: That is what I think he said. I am not saying I believe that.

COMMISSIONER FIRESTONE: If the witness has any views I would prefer if he explained his own views.

THE CHAIRMAN: Is there any suggestion these weren't your views?

MR. WILLS: No, sir, I think they are adequately expressed.

THE CHAIRMAN: They are now the witness' views.

COMMISSIONER FIRESTONE: With some help from the Commissioner.

THE CHAIRMAN: Some help, proper help, yes.

COMMISSIONER FIRESTONE: Mr. Wills, on the question as to whether the medically-sponsored organization could provide a more efficient administrative agency than the Government agency; would you agree with that?





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Wills

10453

MR. WILLS: I would think they would initially, at least, Dr. Firestone, but whether it would continue is another question.

COMMISSIONER FIRESTONE: That is your answer, sir; thank you very much. The third contributing factor to increased costs would be providing essential medical services to the needy. That would be another factor in increasing costs, but as I understand it you approve of such increased costs, if I understand your views expressed in paragraph 20 on page 8 correctly.

MR. WILLS: Yes, sir, I think so.

COMMISSIONER FIRESTONE: And the fourth factor would be increased costs because of rising population. That is something we have to take into account in any growing economy.

MR. WILLS: Yes.

COMMISSIONER FIRESTONE: All I am coming to, when you examine all the four major factors that may be contributing to rising costs, it seems that there are ways and means of dealing with these factors, some of which are under control and some of which are not under control, such as medical care services required by rising population.

Would you feel one could develop a plan that would deal with and try to avoid some of these abuses that you have in mind in paragraph 29 now that we have discussed some of the major ingredients to such costs?

MR. BARRETT: There is one thing, perhaps, I think we should point out here; that is, an



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MR. WILLS: Yes.

COMMISSIONER FIRESTONE: All I am

trying to say is that, while it is true that there may be contributing to rising costs, it seems that there are ways and means of dealing with these factors, some of which are under control and some of which are not under control, such as medical care services required by rising population.

Would you feel one could develop a plan that would deal with and try to avoid some of these items that you have in mind in paragraph 20 now that we have discussed some of the major ingredients to such costs?

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Barrett

10454

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4 health schemes, particularly in Britain. On the  
5 matter of drugs and the use of drugs, it is very diffi-  
6 cult to control that under this scheme, simply because  
7 if there is any question that the drug will help the  
8 doctor may use it. It is a little bit difficult for  
9 him to decide what quantity and when. This is one of  
10 the problems in this type scheme, one problem that has  
11 resulted in Great Britain, as you are aware.

12 COMMISSIONER FIRESTONE: Presumably  
13 the suggestion you put in earlier of co-insurance  
14 would help. If anyone wants to obtain a prescribed  
15 drug, if he pays \$1 or \$2 on every prescription that he  
16 purchases, this sort of principle that has already  
17 worked, could be applied on a much broader scale.  
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G/hm

10455

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4 The main question that I am really  
5 coming to is whether you do not feel that some of the  
6 fears that have been expressed as to the difficulties  
7 and inadequacies cannot be coped with using the four  
8 areas of cost increases which we have discussed?

9 MR. WILLS: Probably.

10 COMMISSIONER McCUTCHEON: Are you  
11 referring to a national plan?

12 COMMISSIONER FIRESTONE: I am referring  
13 to the phrase used in paragraph 29 that:

14 "Any national scheme of health

15 "insurance would undoubtedly be

16 "subject to a great many abuses which

17 "are very difficult to control."

18 I am referring to that statement in that paragraph.

19 MR. WILLS: I think we feel that they  
20 cannot be completely controlled, Dr. Firestone, but they  
21 can be controlled to some degree.

22 COMMISSIONER FIRESTONE: Thank you very  
23 much, that is very helpful.

24 MR. CONNOR: It might initially be  
25 possible to put on the drawing board a plan that one  
26 might think would solve these problems, but what would  
27 happen after a period of operation, when everyone felt  
28 that they were entitled to these things strictly as a  
29 matter of right, with no reference to cost, might be  
30 another matter entirely.

COMMISSIONER FIRESTONE: Well, would  
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6 MR. CONNOR: No sir, I don't think  
7 it could be improved without competition.

8 COMMISSIONER FIRESTONE: Even in the  
9 light of experience?

10 MR. CONNOR: No, I don't think in this  
11 area.

12 MR. PERRY: Most plans have many  
13 co-insurance features, such as paying after the fourth  
14 visit, and all sorts of limits which tend to be co-  
15 insurance features, and I think it is the experience of  
16 every company introducing plans for its employees that  
17 the costs pyramid, even with the preconceived, built-in  
18 features, that you would think would control it, and  
19 I am just adding to what Mr. Connor has said. It is the  
20 feeling that it is there, and they are losing it if  
21 they are not using it.

22 COMMISSIONER FIRESTONE: I take it  
23 from what you are saying that that has been the experience  
24 of industry using these employer-employee benefit plans,  
25 and that you would expect that a somewhat similar  
26 experience would be in a national plan?

27 MR. CONNOR: It would be no different  
28 population. We have a pretty good cross-section.

29 COMMISSIONER FIRESTONE: Well, if the  
30 experience is similar, well what is then the objection?

MR. CONNOR: Well, perhaps all I am  
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Connor

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4 predict would be your costs.

5 COMMISSIONER FIRESTONE: And that  
6 experience would be similar to that experienced by  
7 industry?

8 MR. CONNOR: Yes sir.

9 THE CHAIRMAN: And of course what you  
10 said was it would be compounded in a monopoly?

11 MR. CONNOR: Correct.

12 MR. WILLS: May I make a couple of  
13 observations that are a little aside from what we have  
14 been talking about?

15 THE CHAIRMAN: Yes.

16 MR. WILLS: There are a decreasing  
17 number of wage earners in ratio to industry nowadays,  
18 and I think we must consider that all of us at this  
19 table are employees, and there will be in the years to  
20 come less wage earners in relation to industry, so when  
21 we are talking about wage earners or employees we must  
22 of necessity embrace the whole group.

23 The second thought I would like to  
24 express to you is that we have said that none of these  
25 social measures can be taken in isolation. The advent  
26 of social security probably in many, many employers'  
27 cases pre-dates bargaining. In the latter part of the  
28 '40's many companies unilaterally installed benefit  
29 programs. It would be hard to find two companies with  
30 similar programs, because of the nature of the  
entrepreneur and the nature of this benefit and that  
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employees from other places, because qualified people were



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6 installing these programs the employers considered  
7 what they could afford, and having installed it felt  
8 that was all they could afford. Then measures that  
9 have come up since by bargaining, Royal Commissions or  
10 otherwise, imposed costs on top of what they felt was  
11 the maximum they could afford. Had they known that  
12 these other items would come up they would not have been  
13 as liberal in the other areas. They are in no position  
14 now to reduce these other areas, so nothing can be  
15 taken in isolation. It must be considered as part of  
16 the whole package.

17 COMMISSIONER BALTZAN: I am just  
18 going to put one general question to you. It is contended  
19 by many that because Canada has not an overall general  
20 health services plan it is not keeping up with the  
21 modern trends or modern times. Following upon that,  
22 is that sort of a fixed system absolutely necessary if,  
23 number one, the deficiency areas as we find them are  
24 corrected, and you pointed out some deficiency areas,  
25 and if there is at the same time every assurance for the  
26 advancement and progress of the best skills at all  
27 levels? Do we to make up for these deficiencies,  
28 recognize and also ensure that we are making progress,  
29 then do we need to have a national health services plan  
30 formulating an outline of procedure?

MR. WILLS: I would say that what  
Canada should have is what is best for Canadians, rather  
than to copy other countries. The danger here is that



back to front.

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have come up since by bargaining, Royal Commissions or  
otherwise, imposed costs on top of what they felt was  
the maximum they could afford. Had they known that  
these other items would come up they would not have been  
as liberal in the other areas. They are in no position  
now to reduce these other areas, so nothing can be  
taken in isolation. It must be considered as part of  
the whole package.

COMMISSIONER BARTON: I am just

going to put one general question to you. It is contained  
by many that because Canada has not an overall general  
health services plan it is not keeping up with the  
modern trends of modern times. Following upon that,  
is that sort of a fixed system absolutely necessary if,  
number one, the deficiency areas as we find them are  
corrected, and you pointed out some deficiency areas,  
and if there is at the same time any measure for the  
advancement and progress of the best skills at all  
levels? Do we to make up for these deficiencies,  
recognize and also ensure that we are making progress,  
then do we need to have a national health services plan  
formulating an outline of procedure?

MR. WILKS: I would say that what

than to copy other countries. The one in fact is that



Wills

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4 we tend to want to copy the most advantageous develop-  
5 ments in other countries. We cannot afford to do that.  
6 In Japan for instance, when you hire an employee he  
7 is your employee for life. You don't lay him off. Are  
8 we suggesting that we should have a health plan equal  
9 to the best in the world? I think we should have a  
10 program that is best fitted to our own people, to the  
11 extent that we can afford them, and perhaps to a slightly  
12 larger extent than we can afford them, but not too  
13 much.

14 COMMISSIONER BALTZAN: Well, if we  
15 have not a plan similar to people who have national  
16 plans does not mean that the contention is right, that  
17 we are behind modern times?

18 MR. WILLS: Right.

19 COMMISSIONER BALTZAN: And secondly,  
20 that without any given plan, if we in Canada make sure  
21 of the two things I mentioned, correct any of the  
22 deficiency areas, and make sure we are making progress  
23 and meeting Canadian standards?

24 MR. WILLS: I think we could be content  
25 with ourselves, yes sir.

26 THE CHAIRMAN: Thank you very much  
27 gentlemen. We are very grateful to you for the work that  
28 you put into making your submission, and for your  
29 appearance here this morning.

30 MR. WHITELAW: In my opening remarks  
I addressed the Chairman and the Gentlemen of the  
Commission, and I omitted a reference to Miss Girard,  
and as a former Montrealer of recent vintage in Toronto,



While

we tend to want to copy the most advantageous develop-  
 ments in other countries. We cannot afford to do that.  
 In Japan for instance, when you hire an employee he  
 is your employee for life. You don't lay him off. Are  
 we suggesting that we should have a health plan equal  
 to the best in the world? I think we should have a  
 program that is best fitted to our own people, to the  
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 larger extent than we can afford them, but not too

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 of the two things I mentioned, correct any of the  
 deficiency areas, and make sure we are making progress  
 and meeting Canadian standards?

MR. WILKS: I think we could be content  
 with ourselves, yes sir.

THE CHAIRMAN: Thank you very much

Gentlemen. We are very grateful to you for the work that  
 you put into making your submission, and for your  
 appearance here this morning.

MR. WILKS: In my opening remarks

I addressed the Chairman and the Gentlemen of the  
 Commission, and I omitted a reference to Miss O'Leary,  
 and as a former Montrealer of recent vintage in Toronto,





Whitelaw

10460

that is an unpardonable omission;

COMMISSIONER GIRARD: You are forgiven  
sir.

MR. WHITELAW: Thank you gentlemen  
for your attention. We will be happy to supply you with  
the additional information you requested we place at  
your disposal.

THE SECRETARY: The next brief is  
the Canadian Chiropractic Association, to be known as  
exhibit 287, and this will include their exhibits 1  
to 27, as per my index.

Dr. Morgan will introduce his group.

---EXHIBIT NO. 287: Submission of the Canadian  
Chiropractic Association,  
and the following.

Exhibit 1: Canadian Chiropractic Association  
charter, by the Honourable John Whitney  
Pickersgill, Secretary of State of  
Canada, December 10, 1953.

Exhibit 1: Canadian Memorial Chiropractic College:  
Canadian Memorial Chiropractic College  
Calendar, Toronto, Ontario.

Exhibit 2: Canadian Memorial Chiropractic College:  
The Theory and Practice of Postural  
Measurement by Lyman C. Johnston.

Exhibit 2: By-laws of the Canadian Chiropractic  
Association.

Exhibit 3: Canadian Chiropractic Association Code  
of Ethics.

Exhibit 3: Canadian Memorial Chiropractic College  
- Monograph on "Chiropractor", March  
1962.

Exhibit 4: Form letter and attached survey form  
forwarded to various professional  
associations by Dr. M. B. Dymond,  
Minister of Health, March 1, 1960;  
Letter (photostat) from Mr. L.B. Leppard,  
Ontario Dept. of Health, Sept. 19, 1960







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4 sent to Mr. D.C. Sutherland, Executive  
5 Secretary, Ontario Chiropractic  
6 Association, Toronto, Ont. and attached  
7 photostated Interim Report  
8  
9 Exhibit 4: Canadian Memorial Chiropractic College,  
10 Reports on Chiropractic- University  
11 of Toronto Medical Journal.  
12  
13 Exhibit 5: Canadian Memorial Chiropractic College  
14 - Chiropractic and the Challenge  
15 of Progress.  
16  
17 Exhibit 5: Affidavit - Honorable Andrew J. Sordoni,  
18 Chairman of the Board, Sordoni  
19 Enterprises. (photostat)  
20  
21 Exhibit 6: Canadian Chiropractic Association -  
22 Copy of Brief on Physical Fitness  
23 submitted to Mr. Harry Price, Chairman,  
24 Physical Fitness Study Committee -  
25 Government of Ontario by the Physical  
26 Fitness Committee of the Ontario  
27 Chiropractic Association Inc. also  
28 copy of letters to Mr. Harry Price  
29 from Mr. D.C. Sutherland, letter from  
30 Mr. Leslie M. Frost to Mr. D.C.  
Sutherland.  
Exhibit 7: Canadian Chiropractic Association - A  
Study of Public Attitudes Towards  
Chiropractic and its Legal Status  
in British Columbia.  
Exhibit 8: Canadian Chiropractic Association -  
Attitude Study for the Chiropractors  
Association of B.C. conducted in the  
City of Vancouver, Dec. 1955.  
Exhibit 9: Canadian Chiropractic Association -  
Nervous and Mental Cases under  
Chiropractic Care pamphlet, based in  
part on a statistical analysis of 400  
nervous and mental cases.  
Exhibit 10: Canadian Chiropractic Association -  
Home Care for the Emotionally Ill by  
H. S. Schwartz, D.C.  
Exhibit 11: Canadian Chiropractic Association, The  
Science and Art of Joint Manipulation  
by Dr. James Mennell.  
Exhibit 12: Canadian Chiropractic Association - Back  
Pain, Diagnosis and Treatment Using  
Manipulative Techniques, by Dr. John  
Mennell.



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- 4 Exhibit 13: Canadian Chiropractic Association -  
Medicine and Chiropractic by C. W.  
Weiant.
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- 6 Exhibit 14: Canadian Chiropractic Association -  
The American Journal of Roentgenology  
and Radium Therapy, Vol. 65, March  
1951.
- 7
- 8 Exhibit 15: Canadian Chiropractic Association -  
the Journal of the Canadian Chiropractic  
Association, Vol. V, No. 4, Oct. -  
Nov. 1961.
- 9
- 10 Exhibit 16: Canadian Chiropractic Association -  
Essentials of Body Mechanics By  
Goldthwait - Brown- Swaim - Kuhns
- 11
- 12 Exhibit 17: Canadian Chiropractic Association -  
Fundamentals of Chiropractic from the  
standpoint of a Medical Doctor, by  
Freimut Biedermann, M.D.
- 13
- 14 Exhibit 18: Press Clipping - Canadian Chiropractic  
Association: taken from The Montreal  
Star, Feb. 7, 1958. "House Committee  
Dooms Chiropractor Measure".
- 15
- 16 Exhibit 19: Canadian Chiropractic Association -  
Chiropractic Principles and Technic  
by Joseph Janse, R. H. House, B. F.  
Wells.
- 17
- 18 Exhibit 20: Canadian Chiropractic Association -  
The Vertebral Column, Life-line of  
the Body, by Fred W. Illi, D.C.
- 19
- 20 Exhibit 21: Canadian Chiropractic Association -  
Massage, Manipulation and Traction,  
Sydney Light, M.D.
- 21
- 22 Exhibit 22: Press Clipping - Canadian Chiropractic  
Association: The Globe and Mail  
Oct. 7, 1961. \$1 billion spent yearly  
on Reducers, Cure-alls, Hair-Growers.
- 23
- 24 Exhibit 23: Canadian Chiropractic Association -  
Extracts from an article by Gerald  
M. Burke, M.D., appearing in "The  
Bulletin of the Vancouver Medical  
Association", March 1958 issue.
- 25
- 26
- 27 Exhibit 24: Canadian Chiropractic Association -  
Chiropractic Offices in Canada -  
photographs depicting modern chiro-  
practic offices in various provinces  
of Canada.
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Exhibit 10:

Canadian Obituaries Association -  
The Canadian Journal of Obituaries,  
Vol. 10, No. 1, March  
1961.

Exhibit 11:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 12:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 13:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 14:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 15:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 16:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 17:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 18:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.

Exhibit 19:

Canadian Obituaries Association -  
Canadian Obituaries Association  
Vol. 10, No. 1, March - June - 1961.



ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

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- 4 Exhibit 25: Canadian Chiropractic Association -  
5 A Survey and Analysis of the Treatment  
6 of Sprain and Strain Injuries in  
7 Industrial Cases.
- 8 Exhibit 26: Canadian Chiropractic Association -  
9 Research in Health and Industry -  
10 Committee on Research International  
11 Chiropractors Association.
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- Exhibit 27: Canadian Chiropractic Association -  
The Theory and Practice of Postural  
Measurement, by Lyman C. Johnston, D.C.





SUBMISSION OF  
THE CANADIAN CHIROPRACTIC ASSOCIATION

APPEARANCES: W.O. Morgan, D.C., President  
R.K. Partlow, D.C., Vice-President  
D.C. Sutherland, D.C., Executive Secretary  
J.A. Langford, D.C., Chairman, Education Committee  
D.W. Macmillan, D.C., President, Canadian Council of Chiropractic Roentgenology & Dean Canadian Memorial Chiropractic College  
J.S. Burton, General Secretary & Counsel.

Alberta Division:

Manitoba Division:

L.W. Heard, D.C.  
O.C. Berg, D.C.

R. H. Collett, D.C.  
R. M. Rutherford, D.C.

Saskatchewan Division:

Maritime Division:

W.O. Morgan, D.C. L.J.Y. Robichaud, D.C.

Ontario Division:

Quebec Division:

D.C. Sutherland, D.C. J.M. Gaudet, D.C.  
W.R.M. Corrigan, D.C.  
A.C.A. Bathie, D.C.  
H.W.R. Beasley, D.C.  
C.A. Greenshields, D.C.





UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C.

January 10, 1944

Dear Sir:

Enclosed for the Bureau are two copies of a letterhead memorandum from the New York Office, dated January 7, 1944, regarding the activities of the German Propaganda Office in New York City.

Very respectfully,  
J. Edgar Hoover, Director

Enclosure

Enclosure

Very truly yours,  
J. Edgar Hoover, Director

C. C. Rogers, D.C.

Very truly yours,  
J. Edgar Hoover, Director

W. C. Cullen, D.C.

Enclosure

Enclosure

Very truly yours,  
J. Edgar Hoover, Director

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H/ss

DR. MORGAN: Mr. Chairman, if I may

proceed with the reading of the summary of the section known as the Canadian Chiropractic Association.

1. The Canadian Chiropractic Association welcomes this opportunity to express to you its views on the present health services for Canadians and the recommendations for improvement, especially with reference to the profession of chiropractic and its contribution to the field of health care.

2. We are pleased to summarize the contents of this brief and the specific conclusions and recommendations contained therein.

3. The organizational aspects of the Canadian Chiropractic Association and the activities and responsibilities of the various committees are dealt with initially in paragraphs 4 to 15.

4. Chiropractic is a separate and distinct health service, not provided by any other healing art. It is based on the principle that interference to nerve transmission and expression, through vertebral misalignment is a frequent cause of disease, and is a care sought and required by a very large and growing proportion of Canadians, annually.

5. The members of the chiropractic profession make a special and necessary contribution to the health needs of Canadians. Chiropractic has earned and deserves full recognition as a major member of the family of health methods, on an equal basis with the other recognized branches of the healing arts. We recognize that chiropractic is not indicated for all conditions and



1. The purpose of this report is to

present the results of the study of the health of the Canadian population, as shown in the Canadian Health Statistics.

2. This report provides an opportunity to express to you the results of the research health services for Canadians and the recommendations for improvement, especially with reference to the prevention of chronic diseases and the control of the health of the population.

3. It was planned to summarize the contents of this report and the specific conclusions and recommendations in a single document.

4. The objectives of this report are:

a. To provide a summary of the health status of the Canadian population, as shown in the Canadian Health Statistics, and the recommendations for improvement.

b. To provide a summary of the health status of the Canadian population, as shown in the Canadian Health Statistics, and the recommendations for improvement.

c. To provide a summary of the health status of the Canadian population, as shown in the Canadian Health Statistics, and the recommendations for improvement.

d. To provide a summary of the health status of the Canadian population, as shown in the Canadian Health Statistics, and the recommendations for improvement.



Morgan

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under these circumstances we are pleased to refer these patients to qualified members of the appropriate healing art. The members of the chiropractic profession do appreciate the great advances that have been made in medical procedures, particularly surgery, in recent years and for which the people of Canada are grateful.

6. In addition to rendering chiropractic service to the public, the members of the Canadian Chiropractic Association also contribute their abilities, time and effort in such public service projects as "Good Posture Week", "Back to School Spinal Check-up Week", industrial accident prevention and physical fitness programs.

7. Since its rediscovery in 1895, chiropractic has experienced tremendous growth and acceptance. The Canadian Chiropractic Association operates under Federal Charter granted by the Canadian Government in 1953; 87% of the provinces and states of North America have the benefit of chiropractic legislation; the federal government recognizes and finances the education of those veterans returning to civilian life desirous of studying chiropractic; Workmen's Compensation Acts in licensed jurisdictions provide chiropractic services for injured workmen; many health and accident insurance companies provide chiropractic services for their policyholders; the Canadian Legion has repeatedly passed resolutions requesting chiropractic care for veterans; public opinion surveys have indicated a large majority (76%) are in favor of chiropractic care in any national health program; approximately 40% of Canadians have utilized the services







Morgan 10467

of chiropractors and this number is increasing by some 300,000 new chiropractic patients each year.

8. There are conditions present in Canada today which restrict the availability of chiropractic care, and are detrimental to the health of Canadians. These include (a) the lack of chiropractic legislation in Quebec and the Maritimes, excepting New Brunswick, (b) the failure to include chiropractic care in the health services of pension and social welfare legislation in all provinces excepting Alberta and Manitoba, (c) the failure to include chiropractic care in all government health services such as Armed Forces and Department of Veterans' Affairs, (d) the failure to include the services of chiropractors in all policies written by health and accident insurance companies and societies, (e) the failure to include chiropractic care in programs for the mentally ill, (f) the exclusion of chiropractors from tax-supported diagnostic laboratories and hospitals.

9. The official attitude of medicine towards chiropractic has always been one of strong opposition. Very little co-operation has been shown between the members of the two health professions, except perhaps in isolated circumstances on an individual basis. We are aware of the growing volume of evidence of medical acceptance of chiropractic principles and procedures, but never of chiropractors. It would appear that chiropractic procedures are only acceptable to medicine when under medical control and jurisdiction. We strongly submit that chiropractic has a position to fill in the healing arts, as a separate and distinct health service,





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and that interprofessional co-operation must be broadened in order to lessen the hardships imposed upon the patients, whom we both serve. The members of the chiropractic profession in Canada hereby pledge themselves to co-operate with the members of the medical profession for the betterment of the health services of the people of Canada and sincerely trust that this co-operation will be returned.

10. The members of the Canadian Chiropractic Association are prepared and willing to co-operate with governments and all other branches of the healing arts to implement several programs which will improve the health services of Canadians.

11. To encourage post-graduate study, the Income Tax Act should be amended to provide for the deduction for tax purposes, of the expenses and tuition of approved post-graduate training for members of the healing arts.

12. At the present time the citizens of Quebec and the Maritimes (excepting New Brunswick) are denied the security which could accompany chiropractic legislation. We submit that the standards of health services would be greatly improved through the enactment of Chiropractic Acts in those provinces.

13. We also suggest that industry would do well to consider a program providing chiropractic care for employees at the place of employment, with the view of improving the health of employees as evidenced by Senator Sordoni's statement.

14. We recommend a program utilizing the services of chiropractors in industrial accident prevention







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surveys, directed at reducing the number of spinal injuries occasioned through presently unrecognized and unnecessary work hazards.

15. We strongly suggest that preservation of health is more desirable than treatment of disease, and with prevention in mind, we recommend a program of public education to emphasize the importance of posture, spinal mechanics and physical fitness as major factors in the prevention and correction of disease.

16. We further recommend a program of regular chiropractic spinal examinations for school children, designed to detect structural deviations at an early age as a means of preventing disease.

17. Whereas most citizens of Canada, whose health needs are provided through government programs, are presently denied the services of chiropractors, we would recommend that these programs (i.e. old age, social assistance, Department of Veterans' Affairs, Armed Forces and the mentally ill) be extended to include chiropractic care.

18. We suggest that chiropractors should be afforded the use of such tax-supported institutions as public hospitals, diagnostic laboratories and rehabilitation centres.

19. In view of the fact that the most costly aspect of illness may well be loss of income, we would suggest that consideration should be given in the near future to a program that will replace a portion of the income lost through illness.

20. The Association submits that the health



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that the results of the present study are  
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of the nation is its most important asset: that the people of Canada should receive the most complete health care possible; that all people should be afforded the right to adequate health care, regardless of their financial circumstances: that all people should be afforded the freedom of choice of health method and practitioner: and that a government-sponsored tax-supported health care program including all recognized branches of the healing arts, is the best means available of ensuring improved health services for all Canadians. The Association recommends that the overall health program should encompass four co-ordinated fields of endeavour, (1) "Health Services" - to provide comprehensive health care for all Canadians, (2) "Health Facilities" - to ensure adequate facilities and personnel with which to provide comprehensive health services, (3) "Research" - to foster and support desirable research projects (4) "Preventive Health" - to provide programs directed towards improved standards of sickness and accident prevention. We pledge the support and co-operation of the Canadian Chiropractic Association with all levels of government and all branches of the healing arts to implement this program.

21. The complete program, including services, facilities, prevention and research, should be financed through taxation. In our opinion, a plan in which health care is dependent on the payment of premiums is doomed to failure through delinquency.

22. Due to the financial position of graduates from colleges in the healing arts, we would recommend the establishment of low interest loans to such







1 graduates, to assist in the establishment of their  
2 offices. In order to encourage graduates to establish in  
3 isolated areas with a ratio of practitioner to population  
4 below the desired level, such loans should be interest free.

5 23. ~~... of the~~ We submit that funds should be made  
6 available for research in chiropractic on a basis compara-  
7 ble with the other recognized branches of the healing arts.

8 24. ~~... submitted~~ WL submit that the comprehensive program  
9 should commence with health care for all children under 18  
10 years and those over that age actively enrolled in institu-  
11 tions of learning. The program should also include all  
12 those who through financial circumstances are unable to  
13 provide their own health care. All Canadians should be  
14 included as rapidly as personnel and facilities will per-  
15 mit. Preventive and research programs should be developed  
16 simultaneously.

17 25. ~~... of the~~ We, the members of the chiropractic pro-  
18 fession will certainly continue to fulfill our obligations  
19 in the field of health services, and we pledge our support  
20 and cooperation towards a comprehensive program of improved  
21 health care for the people of Canada.

22 Mr. Chairman and Members of the Commis-  
23 sion, I will now ask Mr. John S. Burton to read the sum-  
24 mary of the British Columbia Division of the Association.

25 MR. BURTON:

26 1.- The Chiropractors' Association of British Columbia  
27 associates itself with the Brief of the Canadian Chiroprac-  
28 tic Association of which this is an Appendix. (Pars. 1 & 2)  
29 2.- The main purpose of the Brief is to outline the  
30 history of chiropractic in the province,



1. Graduate, to assist in the work of the school.

2. Officer, in order to give more graduates to the school.

3. Teacher, to assist in the work of the school.

4. Librarian, to assist in the work of the school.

5. Nurse, to assist in the work of the school.

6. Cook, to assist in the work of the school.

7. Janitor, to assist in the work of the school.

8. Messenger, to assist in the work of the school.

9. Student, to assist in the work of the school.

10. Teacher, to assist in the work of the school.

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25. Teacher, to assist in the work of the school.

26. Officer, to assist in the work of the school.

27. Graduate, to assist in the work of the school.

28. Teacher, to assist in the work of the school.

29. Officer, to assist in the work of the school.

30. Graduate, to assist in the work of the school.



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define its legal position and portray its acceptance by the people of the province.

3. Since the passage of the Chiropractic Act in 1934, the Board of the Chiropractors' Association has administered the Act wisely and well. (Pars. 8 & 9)

4. All practising chiropractors must belong to the Association created by the Act. It is administered by a Board and an Examining Board, which operate under regulations enacted by the Board, approved by the Lieutenant-Governor-in-Council. (Pars. 10-13)

5. Subject to the Act, the Board prescribes educational and moral qualifications necessary for admittance to the Association, disciplines its members, administers the Act generally, and controls the Association in all its functions. (Pars 12-14)

6. Practice in the Province is confined solely to chiropractic, - X-ray is used for diagnostic purposes. (Par. 15)

7. The number of practitioners has more than doubled since the Act was passed in 1934. (Par. 19)

8. Chiropractic is accorded complete recognition under the Workmen's Compensation Act. (Pars. 21-26)

9. A recent survey furnished reliable statistics on average cost of establishing a practice, operational expenses, income, number of patients receiving chiropractic care and other important data. (Pars. 27&28)

10. Educational advancement in post-graduate studies is described in Paragraphs 29 & 30.

11. The Association functions as a closely-





negative the legal position and having its consequences  
the people of the province.

3. Since the passage of the Rhinoceros

Act in 1907, the Board of the Rhinoceros Association

has administered the Act wisely and well. (Para. 8-10)

4. All practicing veterinarians must belong

to the Association created by the Act. It is administered

by a Board and an Executive Board, which operate under

regulations enacted by the Board, approved by the

Legislature. (Para. 10-11)

5. Subject to the Act, the Board is authorized

to make rules and regulations necessary for the

exercise of the Association, which are subject to

approval of the Legislature, and which are subject to

revision in all the following: (Para. 11-12)

6. Section 13 of the Act provides that

solely to the Association, - namely, to the Association

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knit organization through Regional Societies and Committees. (Pars. 32-37)

R E C O M M E N D A T I O N S

12. The Association adopts the recommendations of the Canadian Chiropractic Association and stresses:

(1) The need of improved availability of chiropractic services.

(2) Any Health Care Program should allow freedom of choice of chiropractic and all recognized healing services.

(3) Greater emphasis should be placed on prevention of disease. (Pars. 38-41)

THE CHAIRMAN: Thank you, Mr. Burton.



with organization for the purpose of the study.

THE STUDY

The study is a descriptive study of the situation of the study area.

(1) The study is a descriptive study of the situation of the study area.

(2) Any data that is collected will be used for the purpose of the study.

The study is a descriptive study of the situation of the study area.

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The study is a descriptive study of the situation of the study area.



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DR. MORGAN: Mr. Chairman, members of the Commission, I would like to now present Dr. L.W. Heard who will present the Alberta Section.

DR. HEARD: Mr. Chairman, members of the Commission:

SUMMARY

1. The Alberta Chiropractic Association supports the brief of the Canadian Chiropractic Association and adopts its recommendations. This is an appendix to that brief and outlines some salient features pertaining to the profession in Alberta. (Pars. 1 - 3)

2. The history of the Association since the first Act in 1923, is reviewed and its growth, proportion of chiropractors to population are outlined in paragraphs 4 to 8.

3. The pre-requisite qualifications of chiropractors consist of Senior Matriculation and a four-year course in an approved chiropractic college. The Board of the Association controls the profession in respect to admission of practitioners to membership in the Association, discipline of members, etc. (Pars. 9 & 10).

4. A survey conducted in July, 1961, revealed the investment of chiropractors in their offices, extent of practice as to chiropractic care received by patients and other important statistics. (Pars. 11 - 13)

5. Chiropractors spend much time in conventions and educational seminars. (Par. 14)

6. Chiropractic is recognized under







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Workmen's Compensation and by many sickness and accident insurance companies. (Pars. 15 & 16)

7. The Government of Alberta has extended the privilege of chiropractic care to pension recipients and their dependants under a contract entered into between the Government and the profession. Statistics are presented as to the extent of this chiropractic care. (Pars. 17 - 19)

8. The definition of chiropractic, adhered to by all practitioners, outlines the scope of practice, including the use of X-ray. (Pars. 20 - 22)

9. The Constitution of the Alberta Chiropractic Association under the Act is outlined in paragraph 23. A Council, committees with geographical representation, the duties to be performed, and other organizational matters are also outlined in paragraph 23.

10. The Association most strongly believes that only by an unfettered freedom of choice of health practitioner by the people of the Province, can democracy be best served. (Pars. 24 & 25)

THE CHAIRMAN: Thank you, Mr. Heard.

DR. MORGAN: Mr. Chairman, members of the Commission, I must apologize for the fact that the Province of Saskatchewan was unable to send a delegate to this hearing and I have been asked to present their brief on their behalf.

#### SUMMARY

1. The Chiropractors' Association of Saskatchewan submits the brief herein as an appendix to that of the Canadian Chiropractic Association and the



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Worshipful's Corporation and by their officers and agents

1. The Government of Alberta has

extended the privilege of chiropractic to persons

qualified to and their dependents under a contract

entered into between the Government and the profession.

That this was proposed as to the extent of this

chiropractic law. (Para. 17 - 18)

2. The definition of chiropractic,

referred to by all parties, outlines the scope

of practice, including the use of X-ray. (Para. 20 - 22)

3. The definition of the right

chiropractic association under the Act is outlined in

paragraph 23. A Council, composed of representatives

of the profession, the duties to be performed, and other

regulations and matters are also outlined in paragraph 24.

4. The association must thereby

believe that only by an authorized freedom of the

it has in practice by the people of the Province,

and thereby be best served. (Para. 25 & 26)

5. The Association, in its

of the Association, must be satisfied that the law that

the law has been enacted and is to be in force

that the law is in force.

That the law is in force.

That the law is in force.



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members of the profession in this Province endorse the recommendations and conclusions and accept the facts contained in that brief and that of the Canadian Memorial Chiropractic College. The legal position of the Association and the particular position of chiropractic in the Province is outlined. (Pars. 1 & 2)

2. The "Chiropractic Act" in Saskatchewan was passed in 1943 and an outline is given of its operation, the requirements for admission to membership in the Association and to practise in Saskatchewan, examinations conducted in association with the University of Saskatchewan and the general powers of the Board in the administration of the Act. (Pars. 3 - 7)

3. Chiropractic as it exists in Saskatchewan today, the number of licensed practitioners, the distribution by area, the ratio of chiropractors to population, the average number of patients receiving chiropractic care per year, the costs of establishing an office, and other pertinent facts relating to the actual conduct of the practice of chiropractic, is outlined in paragraphs 8 to 13.

4. The Association conducts two major public service programs, namely "Correct Posture Week" in May and "Back to School Spinal Check-up Week" in September of each year. Many children are examined through the co-operation of the Regina City Council and the number of patients utilizing this service is increasing year by year. (Pars. 14 & 15)

5. The Association co-operates with the Physical Fitness and Recreation Departments of the







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Government of Saskatchewan. (Par. 16)

6. Various groups such as the Canadian Memorial Chiropractic College Alumni Association and the Canadian Council of Chiropractic Roentgenology assist in the work of the Association. (Pars. 17 & 18)

7. The Workmen's Compensation Board of the Province extends the right to injured workmen to choose chiropractic health care and pays for such services. Many insurance companies do likewise. (Pars. 19 & 20)

8. The Department of Health does not extend prepaid chiropractic service to social welfare cases as is done in Manitoba and Alberta. (Par. 21)

9. The new Health Care Plan initiated by the Government in Saskatchewan is likely to provide a very comprehensive health service, in which chiropractic is expected to be included. (Pars. 23 & 24)

10. Chiropractic is increasing in popularity in government departments, unions, insurance companies, etc. (Par. 25)

11. In conclusion, the Association submits that chiropractic has proven that it has the right to be accepted as one of the healing arts which should be recognized in any Health Care Plan, that it has been accepted by the people in overwhelming numbers and that it is the right of all people to seek the healing profession of their choice. (Pars. 26 - 28)

THE CHAIRMAN: Thank you, Mr. Morgan.

DR. MORGAN: Mr. Chairman, members of the Commission, if I may now introduce our representative





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from Manitoba, who will read that summary, Dr. R.H. Collett.

DR. COLLETT: 1. The Manitoba Chiropractors' Association associates itself with the brief of the Canadian Chiropractic Association of which this is an Appendix. (Par. 1)

2. The Association urges that in any health program, chiropractic should be included as one of the healing professions and the main purpose of this brief is directed to the accuracy of this submission and to outline the position of chiropractic in Manitoba. (Pars. 2 to 4)

3. The history of chiropractic in Manitoba has demonstrated that the Association, through its administrative bodies, has conducted the affairs of the Association with credit to itself and for the benefit of the people of Manitoba. (Pars. 5 to 8)

4. The record of achievement of chiropractic in the Province of Manitoba is outlined with particular reference to acceptance by Labour Unions, government bodies, other organizations and citizens of the province. (Pars. 9 to 13)

5. Chiropractic is a separate science offering a service not made available by any other healing profession and chiropractors are qualified to render a distinct health service to all residents. (Pars. 14 & 15)

6. Workmen's Compensation Board, the Manitoba Government, through its Medicare Program, and many insurance companies recognize the efficacy of







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chiropractic in their health services. (Pars. 16 to 18)

7. The Honourable George Johnson, M.D., Minister of Health of Manitoba, has made a presentation to this Honourable Commission, which has been quoted in part in paragraph 19, recommending that a comprehensive plan of health services include non-medical groups.

8. The Manitoba Conservative Party passed a resolution asking for the utilization of chiropractic services under any government health program. (Par. 20)

9. Information is provided in respect to the number of members of the Manitoba Chiropractors' Association and statistics quoted as to costs of establishing practices, expenses, income, etc. (Par. 22)

10. In its conclusion, the brief emphasizes certain recommendations contained in the brief of the Canadian Chiropractic Association in respect to public acceptance of chiropractic and the right of people to choose practitioners of health whom they believe are best able to render them health service. (Par. 23)

THE CHAIRMAN: Thank you, Mr. Collett.

DR. MORGAN: Mr. Chairman, could I once again introduce Mr. L.J.Y. Robichaud on behalf of the Maritime Division.

DR. ROBICHAUD: Messieurs les membres de la Commission et Mademoiselle Girard.

1. The Maritime Division is composed of the four Maritime Provinces, which by reason of a small number of practitioners is grouped as a unit and





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entitled to one member on the National Board of the  
Canadian Chiropractors' Association. (Par. 1 & 2)

2.. The Maritime Division associates  
itself with the briefs of the Canadian Chiropractic  
Association and the Canadian Memorial Chiropractic  
College. (Par. 3)

NEW BRUNSWICK

3. A short history of chiropractic  
in New Brunswick is outlined in Paragraph 4.

4. The provisions of the Act relating  
to the definition of chiropractic, objects for which the  
Act was enacted and a description of the Board is  
contained in Paragraphs 4-8 inclusive.

5. Qualifications for membership in  
the Association and the right to practise is described  
in Paragraphs 9-11.

6. The Board controls the profession  
under regulations passed by authority, and contained,  
in the Act, the examinations being conducted by an  
Examining Board. (Pars. 12 & 13)

7. The growth of chiropractic in  
New Brunswick has been very pronounced and chiropractors  
have the most modern equipment available. (Pars. 14 &  
15)

8. Chiropractic recognition under the  
Workmen's Compensation Board and insurance companies is  
described in Paragraphs 17 and 18.

9. Results of a survey conducted by  
the profession show the statistics of average number of  
years in practice, cost of establishing offices, number





entitled to one member on the National Board of Directors.

2. The National Board of Directors

shall consist of the representatives of the Canadian Chiropractic Association and the Canadian Chiropractic College.

College. (P. 1, 2)

NEW BRUNSWICK

3. A short history of chiropractic

in New Brunswick is outlined in paragraph 4.

4. The provisions of the Act relating

to the definition of chiropractic, and the scope of which are

not included and a list of the Board is

contained in paragraph 5.

5. The Board of Directors

the Association and the right to practice is contained

in paragraph 6-11.

6. The Board of Directors

under regulations passed by the Board, and contained

in the Act, the Board of Directors is authorized to

exercise powers, (para. 12 & 13)

7. The growth of chiropractic in

New Brunswick has been very rapid and is increasing

have the use of the same in the future. (para. 14)

8. The Board of Directors

shall have the right to make regulations for the purpose of

carrying out the provisions of the Act.

9. The Board of Directors

shall have the right to make regulations for the purpose of

carrying out the provisions of the Act.



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of house and office calls, numbers of new patients, and other statistics.

10. There is a great need for more chiropractic practitioners. (Par. 19)

11. In conclusion, New Brunswick reiterates that every person should have freedom of choice of health practitioner. (Par. 22)

NOVA SCOTIA

12. The Province of Nova Scotia adopts the brief of the Canadian Chiropractic Association, the Canadian Memorial Chiropractic College and the submissions herein of the New Brunswick Association. (Par. 33)

13. Nova Scotia does not have the advantage of legislation which materially prejudices chiropractors and the public. (Par. 24)

14. The short history of chiropractic in Nova Scotia outlines the incorporation of the Association under the "Societies Act" and reviews its attempts to obtain legislation. (Pars. 25 & 26)

15. The Canadian Legion many times requested recognition of chiropractic care under the Department of Veterans' Affairs and the Workmen's Compensation Board. (Par. 27)

16. The Government of Canada has spent over one million dollars to train chiropractors but the Provincial Government of Nova Scotia does not grant these veterans the right to practise in the province. (Pars. 28 & 29)

17. All Canadian war veterans must pay





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for chiropractic care out of their own pockets, sometimes out of the service compensation which they receive from the Department of Veterans' Affairs. A similar situation exists in respect to Workmen's Compensation. (Pars. 30 & 32)

18. Major insurance companies have attempted without success to convince the government to enact chiropractic legislation. The Nova Scotia Federation of Labour has made similar requests in briefs presented to the Legislature and to a Royal Commission in respect to Workmen's Compensation. Judge McKinnon, the Commissioner in respect to the Enquiry, strongly recommended the legislation of chiropractic in the province. (Pars. 33 - 38)

19. Demand for chiropractic services on a legal basis has been voiced by a large percentage of the people of the province. (Pars. 39 & 40)

20. The growth of chiropractic in the province and the pre-requisites for admission to the Association are described in Paragraphs 42 and 43.

21. A survey of the profession in Nova Scotia has shown valuable statistics in reference to cost of establishing offices, number of office and house calls, new patients, attendance at conventions, etc. (Pars. 44 & 45)

22. The Nova Scotia Association recommends that a study be given to the principle of establishing a basis whereby health services (hospital cases) may be given in their homes to patients. (Par. 46)







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23. Absolute choice of health practitioner should be granted to the people." (Par. 47)

I offer a few corrections to be made, with your permission, Mr. Chairman. Page 1 of the brief, there are two Dr. Robichauds. One is my brother. The first here, the Board of the Maritime Division, L.J.Y., and that is the third name, Secretary-Treasurer. I am also the representative of the Canadian Chiropractic Association.

On page 4, paragraph 15, the second to the last line, "The standard of chiropractic in any province..." should be, "The standard of chiropractic in the province..."

Page 5, sub-paragraphs (e), (f), (g) and (h), take out the dollar signs.

Page 6, paragraph 21, the last line, "Health programs of a compulsory nature", please add, "or non-compulsory" so it will read, "Health programs of a compulsory or non-compulsory nature." That is all.

THE CHAIRMAN: Merci beaucoup, Monsieur Robichaud.

DR. ROBICHAUD: Bienvenué, Monsieur le Président.



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10. Absolute choice of health program

There are also granted to the people. (Part. 17)

I offer a few corrections to be made,

with you, particularly, Mr. Chairman, page 1 of the  
sheet, there are two Mr. Robinsons. One is my brother.

The first name, the name of the Maritime Division,  
N.Y., and that is the third name, Secretary-Treasurer.  
I am also the representative of the Canadian (Ontario) Association  
of Physicians.

to page 4, paragraph 15, "the second to

the last line, "the second of Ontario is also  
provisional..." and the last line of Ontario  
in the schedule..."

Page 4, sub-paragraph (a), (1), (g)

and (h), take out the dollar signs.

Page 5, paragraph 21, the last line,

"Health programs of a compulsory nature", change and  
"non-compulsory", as it will read, "Health programs  
of a compulsory nature." That is all.  
THE CHAIRMAN: Thank you very much, please

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Morgan

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DR. MORGAN: Mr. Chairman, may I introduce Dr. D.C. Sutherland to present the Ontario Division.

DR. SUTHERLAND:

SUMMARY AND RECOMMENDATIONS

The Ontario Chiropractic Association respectfully presents this brief to the Royal Commission on Health Services to outline the position and views of the profession in the Province of Ontario.

This presentation forms a part of the submission by the chiropractic profession and it is requested that it be considered in conjunction with those of the Canadian Chiropractic Association, the other provincial divisions, and the Canadian Memorial Chiropractic College.

The introduction in this submission contains the following statements:-

(a). The interests of the citizens of this Province require the availability of the unique services provided by the chiropractic profession,

(b). Residents of this Province should have the right to choice of health practitioner and method of treatment in meeting their health needs,

(c). Efficiency of operation and completeness of health services necessitates the inclusion of chiropractic on an equal basis with the other major recognized healing arts, and

(d). members of the chiropractic profession in Ontario are willing to co-operate in a national health plan.







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3 The historical paragraphs give a brief  
4 outline of chiropractic in Ontario.

5 The Ontario legislation section deals  
6 with the various statutes and regulations applying to this  
7 profession. It will be noted that both the enabling  
8 and restricting provisions are dealt with. Some of  
9 the recommendations which follow are intended to bring  
10 attention to, and suggest improvement in, those areas  
11 where changes are desirable.

12 The professions organizations section  
13 places the relationship of the Ontario Chiropractic  
14 Association to the other chiropractic organizations, and  
15 comments briefly on their respective fields of endeavour  
16 to show the existence of well-established lines of  
17 communication for professional co-operation. This  
18 section deals briefly with the organization and  
19 activities of the Ontario Chiropractic Association.  
20 Many of the educational and public service programs  
21 carried on by this Association are worthy of expansion  
22 and public support, and are therefore dealt with in  
23 the recommendations.

24 Chiropractic Practice in Ontario  
25 depicts the public acceptance of the profession as  
26 an integral part of the essential health services  
27 available in this Province. Chiropractic is defined,  
28 the neuromusculo-skeletal approach to health problems  
29 is discussed, and the relationship of the spinal column  
30 and nervous system to health is outlined. It is  
stated that chiropractic is not a cure-all. The  
contraindications, restrictions, limitations of chiropractic,



The historical paragraphs give a brief  
outline of chiropractic in Ontario.  
The Ontario legislation section deals  
with the various statutes and regulations applying to this  
profession. It will be noted that with the passing  
of the new legislation provisions are dealt with. Some of  
the recommendations which follow are intended to bring  
attention to, and suggest improvement in, those areas  
where changes are desirable.  
The professions of medicine and dentistry section  
places the relationship of the Ontario Chiropractic  
Association to the other professional organizations, and  
comments on the work of these respective fields of endeavor  
to show the existence of well-established lines of  
communication for professional co-operation. This  
section deals briefly with the organization and  
activities of the Ontario Chiropractic Association,  
many of the educational and public service programs  
carried on by this Association are worthy of expansion  
and public support, and are therefore dealt with in  
the recommendations.  
Chiropractic treatment of various  
sections and public acceptance of the profession as  
an integral part of the essential health services  
available to the public. Chiropractic is outlined,  
the neuromusculoskeletal system to health problems  
as discussed, and the importance of the spinal column  
and nervous system to health is outlined. It is  
stated that this system is not a cure-all. It is





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4 and referral in the patient's best interests are covered.  
5 It is further stated that one who has studied and  
6 practised chiropractic is more competent to give an  
7 intelligent and scientific opinion on chiropractic and  
8 to say what it can or can not do. I might mention here,  
9 Mr. Chairman, that often we find those who would restrict  
10 these services are not really educated in their use and  
11 may be somewhat biased. The exclusion of chiropractors  
12 from practice in, or receiving services from tax-  
13 supported institutions is mentioned to show some of the  
14 detrimental restrictions presently in force. Facilities  
15 for rendering chiropractic services are outlined.  
16 These services are utilized by a cross section of all  
17 socio-economic levels, and referrals to chiropractors  
18 come from this same wide source. It is a constant  
19 regret to this profession that there is not greater  
20 co-operation from the medical profession in the best  
21 interests of the patient. The wide variety of condi-  
22 tions treated in chiropractic offices, including  
23 preventive care, is referred to. The economic aspects  
24 of practice, including a discussion of the various  
25 ways in which services are paid for, such as patients  
26 paying their own accounts. Workmen's Compensation Board,  
27 and the protection offered by private insurance carriers  
28 is detailed. Particular attention is directed to those  
29 discriminatory plans which exclude or restrict chiro-  
30 practic services. The chiropractic profession assumes  
its fair share of social and gratuitous services. An  
estimate of the volume and value of services, and  
expenses is given.







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Part of "The Place of Chiropractic in Ontario" deals with medical criticism of chiropractic. Reference is made to the fact that chiropractic is not an ancillary medical service, but provides an alternate approach which fills a special and particular need, not otherwise available. Some reasons are given to show that it would be impractical to make chiropractic services available on medical prescription. Manpower shortages in the health field necessitate the effective use of all professional skills, and therefore the chiropractor will be required in any health care program.

The final section deals with the future position of the profession and the contribution it will make in providing essential health services in Ontario. It is stated that full utilization of chiropractic services will contribute toward an efficient utilization of the health dollar, as outlined in paragraphs 173, 174 and 175. Attention is drawn to the importance of preventive care through early recognition and treatment by chiropractic methods. This Brief concludes with the statement that the chiropractors in Ontario are willing and competent to render their full share of health services required by the public.

The Ontario Chiropractic Association recognizes the complexities involved in the planning and economic studies necessary for the implementation of improvements in health services. For this reason, the comments contained in this brief are confined to those aspects of health care relating to the part played







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3 by the chiropractic profession in the Province of  
4 Ontario. It will be noted that many of the following  
5 recommendations are similar to those submitted by the  
6 Canadian Chiropractic Association.

7 With respect to improvement of existing  
8 services or any new health plan, the recommendations of  
9 the Ontario Chiropractic Association, Incorporated, are:

10 1. That all citizens be uniformly afforded  
11 the opportunity to be covered under the provisions of any  
12 national health plan.

13 2. That a participating citizen may go  
14 to the practitioner of his choice and may change from  
15 one to another on reasonable cause (except where custodial  
16 or compulsory care restricts, by statute, the individual's  
17 right of choice).

18 3. That chiropractic services be made  
19 available under any national health services plan, or  
20 that chiropractic services be made available in any  
21 health service providing care on an office visit basis  
22 in which there is an expenditure of public funds.

23 4. That the special ability and contri-  
24 bution of the chiropractor be recognized and utilized  
25 in present provisions or future plans without medical  
26 prescription or other restrictions or discrimination.

27 5. That the services of the chiropractor  
28 may be available in individual offices, group practice,  
29 or diagnostic and clinical centres.

30 6. That the scope of conditions treated  
by the chiropractor be those that he is permitted to  
treat by law in the Province of Ontario.







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7. That a chiropractor shall continue to have the authority to accept or refuse to accept any citizen as a patient.

8. That the reasons for refusal by any participating chiropractor for an individual patient may be:

(a) any condition not considered in the chiropractor's judgment to be amenable to his skills.

(b) lack of co-operation by the patient.

(c) limitations required to render efficient service (e.g. office hours and facilities).

9. That the chiropractor has the right to refer patients to any other participating practitioner, when it will serve the best interests of the patient.

10. That any patient failing to co-operate with any reasonable requirement may be dismissed or referred, providing that such patient is not placed in jeopardy.

11. That treatment may be continued for as long as may be deemed necessary in the opinion of the chiropractor.

12. That within a plan, a citizen may receive treatment by different health methods concurrently, but not for the same condition.

13. That any plan will not restrict a citizen from seeking health care on a private patient basis.

14. That a chiropractor may elect to



That the Government should consider the  
the fact that the Government is not a party to the contract.

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the fact that the Government is not a party to the contract.

(A) The Government is not a party to the contract  
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the fact that the Government is not a party to the contract.



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participate in any health plan, or remain solely in private practice.

15. That a chiropractor may participate and also accept other patients on a private patient basis.

16. That reasonable restrictions should be placed upon members of all branches of the healing art in regard to participating or withdrawing from participation in any plan.

17. That a chiropractor may be employed in a salaried position in a centre operated by or for any plan.

18. That the usual method of remuneration for services rendered should be on a fee-for-service basis, in accordance with a schedule of fees agreed upon by negotiation with the Ontario Chiropractic Association.

19. That a "roll" or "panel" system does not appear to be a desirable or efficient method for inclusion of chiropractic services.

20. That a patient be charged a utilization or deterrent fee in order to prevent abuse of services. Such a fee should be paid directly to the practitioner providing the service. An alternate to the foregoing, a deductible provision, would also minimize abuse and reduce administrative costs.

21. That provision be made wherein the services provided under any plan would be restricted to participants who were bona-fide residents or citizens of Canada.





participate in any health plan, or remain solely in private practice.

16. That a chiropractor may participate and also accept other patients on a private patient basis.

17. That reasonable restrictions should be placed upon members of all branches of the healing art in regard to participating or withdrawing from participation in any plan.

18. That a chiropractor may be employed in a limited position in a center operated by or for the public.

19. That the usual method of representation for activities rendered should be on a fee-for-service basis, in accordance with a schedule of fees agreed upon by negotiation with the patient (physician).

20. That a "pool" or "panel" system does not appear to be a desirable or efficient method for the delivery of chiropractic services.

21. That a patient is entitled to a utilization review if he is denied a benefit of services, and a review should be paid directly to the practitioner providing the service. An attempt to the contrary, a review provision, would also minimize abuse and reduce administrative costs.

22. That provision be made for the review of health plans and that they be restricted to participants who were non-residents or citizens of the United States.



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22. That licensing, discipline and control of the profession remain separated from any plan.

23. That grants be allotted to the chiropractic profession for:-

(a) Chiropractic institutions of higher learning located in Canada.

(b) Research grants.

(c) Post graduate studies.

24. That loans be available on reasonable terms for assistance in the establishment of office facilities and/or diagnostic centres.

25. That administration of any plan be so arranged that no one group in commerce or the healing field may dominate or control.

26. That a separate Board of Referees be established, to adjudicate on matters pertaining to the handling of cases by a chiropractor. This Board should be composed of a representative of the plan and two chiropractors.

27. That if priorities are deemed necessary in any plan, implementation be in the following order:-

(a) The immediate inclusion of chiropractic services for the care of acute and chronic conditions, including welfare and public assistance cases.

(b) Preventive care, such as industrial surveys, school posture studies and education, physical fitness.

(c) Graduate practice establishment loans.





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(d) Grants

(e) Research

Mr. Chairman, this summary is respectfully presented on behalf of the Ontario Chiropractic Association. We realize some of the recommendations stated herein are in broad general terms for purpose of establishing a basis of discussion, which we would be happy to do at a later time.

DR. MORGAN: I would like to introduce again Dr. E. W. Macmillan, Dean of the Canadian Memorial Chiropractic College.

DR. MACMILLAN: Before beginning I would like to ask that two changes be made on page S3. On the fourth line "whatsoever to any governmental authority," that at that point "except the Department of Veterans' Affairs" be added and on the last line "to the health of the Canadian people," that the word "and" be put in the place of the word "but". Thank you.

### S U M M A R Y

1. The brief herein is submitted in conjunction with that of the Canadian Chiropractic Association and its main purpose is to acquaint the members of the Commission with the presently available facilities for the education of chiropractors in Canada and the basic objectives and needs of the Canadian Memorial Chiropractic College.

2. The main topics dealt with and the conclusions and recommendations contained in this submission, may be summarized briefly as follows:



(b) Grants

(c) Research

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### CONCLUSIONS

1. The final herein is submitted in  
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Association and its main purpose is to acquaint the  
members of the Commission with the properly evaluated  
facilities for the education of chiropractors in Canada  
and the basic objectives and needs of the Canadian

2. The main points dealt with and the  
conclusions and recommendations contained in this  
submission, may be summarized briefly as follows:



1. An outline of the history of the Canadian Memorial Chiropractic College.
2. The purpose, principles taught and accomplishments of the College.
3. A survey of the courses taught by the College and its record of achievement.
4. The Faculty and Student Body of the College.
5. Its research program.
6. The plans in the process of implementation to enlarge, improve and modernize the physical facilities and equipment.
7. The administration of the College, its financial resources.

3. We believe that the College, as it exists and operates today, serves the Canadian public and the chiropractic profession as well as possible under the circumstances, but that with the advent of the anticipated population increase in Canada, a long-range expansion program now envisioned by the Board of Directors will be necessary to adequately serve the Canadian public in the future. Included in this, no doubt, will be the implementation of a National Health care plan, in which chiropractic should be included upon an equal basis with other health professions.

4. The brief conclusively shows that a degree of higher educational excellence has been maintained comparable to that of other educational institutions of healing professions in Canada.

5. The financial difficulties experienced by the College, to maintain high academic standards, are outlined, and stress is laid on the fact that the College



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5. Its research program.
6. The plans for the process of implementation to enlarge, improve and modernize the physical facilities and equipment.
7. The administration of the College, its financial resources.
8. We believe that the College, as it exists and operates today, serves the Canadian public and the chiropractic profession as well as possible under the circumstances, but that with the advent of the anticipated population increase in Canada, a large range expansion program now envisioned by the Board of Directors will be necessary to adequately serve the Canadian public in the future. Included in this, no doubt, will be the implementation of a national curriculum, in which chiropractic should be included upon an equal basis with other health professions. The policy conclusively shows that a series of high educational excellence has been maintained comparable to that of other educational institutions of health professions in Canada.
9. The financial difficulties experienced by the College, to maintain its academic standards, are outlined, and stress is laid on the fact that the College





has been supported almost entirely by members of the profession, without tax support,

government grants or endowments.

We strongly urge that the Commission will recommend favourably the need for financial assistance to the College, in the interest of the youth of Canada and the health needs of the general public.

6. The lack of sufficient scholarships, grants-in-aid and loan funds seriously handicaps young people in Canada who desire to make the practice of chiropractic their vocation and who are dependent upon such assistance to achieve their goal.

7. The Canadian Memorial Chiropractic College ambulatory clinic has contributed a quality diagnostic and health service at a very modest cost to the lower income residents of Toronto and its environs.

Approximately 50% of this professional service over the past thirteen years has been rendered gratuitously to indigent patients and others of limited means.

Plans for the College building include a clinic, substantially larger and more efficient, which will be capable of serving a much greater number of the population.

8. Contribution to the welfare of children in elementary and secondary schools and the varied research endeavours in connection therewith constitute a very unique field of essential health service, not previously supplied. The wide-spread application of the research findings of the College, materially assists in the prophylactic effort in the field of child care and the knowledge resulting from research can, and does, make a generous contribution to the upgrading of the





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3 physical fitness of Canadian youth and adults as well.  
4 It is conceded that this presently is lamentably low.  
5 This research, as in the United States, is being employed  
6 to advantage by Canadian industry and commerce in the  
7 reduction of employee accidents, fatigue and low  
8 productivity.

9 9. ~~to be~~ The College emphasizes the firm stand  
10 taken by the Canadian Chiropractic Association in its  
11 brief, that Canadian people are entitled to freedom of  
12 choice of health practitioner in matters of health care  
13 and health restoration. The founder of chiropractic,  
14 D.D. Palmer, expressed this as early as 1906 in his  
15 textbook "The Science of Chiropractic - Its principles  
16 and adjustments" page 25 when he said that to force a  
17 person to choose a doctor he may not want is to interfere  
18 with liberty and individual rights. When human liberty  
19 is restricted on any pretext whatever, there is danger  
20 and trouble ahead. It brings the majesty of the law in  
21 disrepute, demoralizes the community in which unjust  
22 laws are enforced, and incites a rebellious spirit.

23 10. The most pressing need of the Canadian  
24 Chiropractic College is financial. It is impossible to  
25 continue the standards already established when 70%  
26 of the income must come from student fees when tax  
27 supported institutions receive only approximately 20%  
28 of their income from fees. The general academic and  
29 physical expansion program cannot be properly carried out  
30 without some direct financial consideration from the  
Federal Government and the Ontario Provincial Government.  
The financial support potential from industrial and  
commercial sources is impossible without the prior



physical fitness of Canadian youth and adults as well. It is conceded that this presently is lamentably low. This research, as in the United States, is being employed to advantage by Canadian industry and commerce in the reduction of employee accidents, fatigue and low productivity.

9. The College emphasizes the firm stand taken by the Canadian Chiropractic Association in its belief that Canadian people are entitled to freedom of choice of health practitioner in matters of health care and health restoration. The founder of chiropractic, D.D. Palmer, expressed this as early as 1898 in his textbook "The Science of Chiropractic - Its Principles and Applications" page 25 when he said that to force a person to choose a doctor he may not want is to interfere with liberty and individual rights. When human liberty is restricted on any pretext whatever, there is danger and trouble ahead. It brings the mastery of the law in discipline, democratizes the community in which unjust laws are enforced, and incites a rebellious spirit.

10. The most pressing need of the Canadian Chiropractic Association is to continue the standards already established when 70% of the income must come from student fees when tax supported institutions receive only approximately 20% of their income from fees. The general academic and physical expansion program cannot be properly carried out without some direct financial consideration from the Federal Government and the Ontario Provincial Government. The financial support potential from industrial and commercial sources is impossible without the aid





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4 recognition of governments. The professional vocational  
5 needs of Canada are great. A student choosing to study  
6 chiropractic as a career profession, will later not  
7 only make a real contribution to the health needs of  
8 Canada, but will also take his or her place as a  
9 responsible contributor to the community in which he  
wishes to serve and dwell.

11. The fact that 669 young men and women  
have been efficiently trained in a useful professional  
vocation without any cost whatsoever to any governmental  
authority except the Department of Veterans' Affairs,  
is in itself a most worthwhile contribution to Canadian  
society and health. Without exception, these men and  
women are making a worthy direct contribution to the  
health of the Canadian people and are also taking their  
places in the different communities across the nation as  
respected and responsible citizens.

12. THE ANTICIPATED NEEDS OF THE  
CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

These can be briefly summarized:

1. Complete recognition as a private,  
non-profit, professional educational institution, serving  
the needs of all Canada and offering education opportunities  
as well to students from foreign countries.

2. Financial -

(a) Immediate Capital Development \$500,000.00

Library and Laboratory \$100,000.00

Building Expansion \$400,000.00 (representing  
25% of the projected expansion program)

(b) Research and Post-graduate annual needs  
\$100,000.00.





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 respected and responsible citizens.

12. CONCLUSION

These can be briefly summarized:

1. Complete recognition as a private,

non-profit, professional educational institution, serving

as well to students from foreign countries,

2. Financial -

(a) Immediate Capital Development \$500,000.00

Library and Laboratory \$100,000.00

(b) The projected expansion program

(c) Research and Post-graduate annual needs



(c) Annual operating grant based on a per capita student allotment at the rate granted to other professional colleges and universities.

(d) Equal recognition given to other professional trainees in the form of loans, bursaries, subsidized tuition grants and practice establishment loans. It is essential that governments give priority to devising ways and means of attracting students to professional studies.

13. It is our opinion that student loan programs should be free from interest charges until the individual is actually earning his or her own living following the completion of his studies.

14. The enrolment objective of the Canadian Memorial Chiropractic College is that the present enrolment should increase to 200 in the next three years and that this figure should double again within ten years.

15. It is ultimately desirable that the Canadian Memorial Chiropractic College should affiliate with an established university. This is not possible until the standards of the physical plant, and faculty salaries be expanded to equal the requirements of state supported educational institutions. This will require a minimum of 5 years. The financial needs outlined in this brief should be sufficient to reach this desirable objective.

16. We submit, with all the power at our command, that the Canadian chiropractic profession and



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ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

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4 this College has clearly demonstrated its capability  
5 to serve the health needs of the Canadian people adequately  
6 and well and should be included in any National Health  
7 Program which may be formulated and recommended by this  
8 Commission on Health Services.  
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Mr. Chairman and Members of the Commission, this concludes the summary of the brief submitted by the Canadian Memorial Chiropractic College.

THE CHAIRMAN: Thank you very much, Dean Macmillan.

DR. MORGAN: Mr. Chairman and Members of the Commission, that concludes the reading of all of the summaries, and we would welcome any questions which you may wish to put.

COMMISSIONER FIRESTONE: May we turn first to Paragraph 8, on Page S-2 of the main brief of the Canadian Chiropractic Association. As I gather, one of the problems your Association is currently facing, and you describe it in Paragraph (c) as, and I quote: "The failure to include chiropractic care in all government health services such as Armed Forces and Department of Veterans' Affairs". Now, sir, has your Association approached the Armed Forces and the Department of Veterans Affairs, and have you suggested to them that such chiropractic care should be provided?

DR. MORGAN: Mr. Commissioner, yes, we have, and I would ask our Executive Secretary, Dr. Sutherland, to answer that specifically.

DR. SUTHERLAND: In 1958, the Canadian Chiropractic Association presented a brief to the Minister of Veterans' Affairs, and again in 1960, when the new Minister, and at that time we appeared before the Veterans Affairs Committee of the Federal Government and made this request in support of the resolution passed by the Canadian Legion. There has been no action on that to my





Sutherland 10500

knowledge to the present time, but the Legion has requested this recognition.

COMMISSIONER FIRESTONE: In making your presentation to the Government, did you submit specific reasons for your recommendations?

DR. SUTHERLAND: Yes, sir.

COMMISSIONER FIRESTONE: Are they somewhat similar to what you have presented to us, or are there additional reasons which are not included in this submission?

DR. SUTHERLAND: No, I believe that everything we said at that time is included in this submission, but we have a copy of that presentation, if you wish to have it.

COMMISSIONER FIRESTONE: If you could make it available to our Secretary?

DR. SUTHERLAND: Certainly.

COMMISSIONER FIRESTONE: Have you received a reply from the Government to your request?

DR. SUTHERLAND: The Legion received a reply to their resolution to the effect that the medical profession considered that they were currently providing the highest possible standard of medical care, and that there was no need for inclusion of our services. We agree that they are providing the highest possible standard of medical care, but we differ with the fact that they are not providing this service. This is not medical care.

COMMISSIONER FIRESTONE: Did you receive a reply in answer to your request?





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COMMISSIONER FIRSTONE: Did you receive a reply in answer to your request?



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DR. SUTHERLAND: We have had a letter from the Minister indicating that this would be under consideration. That is the only comment.

COMMISSIONER FIRESTONE: And when did you receive that letter, that it would be under consideration?

DR. SUTHERLAND: I believe it was a month or two after we appeared.

COMMISSIONER FIRESTONE: What was that date?

DR. SUTHERLAND: In the Fall of 1960.

COMMISSIONER FIRESTONE: And you have not heard from the Government since?

DR. SUTHERLAND: I believe that Dr. McPhail, our representative in Winnipeg, has discussed this with the Minister since, but I am not familiar with any decisions made at that time.

COMMISSIONER FIRESTONE: Have you approached the Minister of National Defence on the same subject with respect to the extension of chiropractic care to members of the Armed Forces?

DR. SUTHERLAND: I believe that that may have been done somewhat before my time. Perhaps Mr. Burton would know better.

MR. BURTON: It was actually done in 1943 the first time, and I don't think the request has been renewed since.

COMMISSIONER FIRESTONE: If you feel as keenly as you say ---- I am just wondering why you have not done anything between 1943 and 1962. Why you have



from the Minister indicating that it would be subject  
consideration. That is not only correct.

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as far as you are concerned I am not

not sure of the details, but I believe that the





Morgan 10502

allowed this thing to go by. Nineteen years is a long time.

DR. MORGAN: I believe the attitude of the profession has been this, that the request has been presented by the Canadian Legion, to encompass both facets, I believe, in the Armed Forces as well as the Department of Veterans' Affairs. That has been adopted at bi-annual conventions of the Canadian Legion since 1946, and each year the request has been relayed to the appropriate Departments in Ottawa, and we are informed that the results have been the same in each case.

COMMISSIONER FIRESTONE: Would you not feel that your own group are perhaps in a somewhat better position to explain the type of services that you provide, and the reasons for the extended use of such services than the users? After all, as suppliers of services you really know perhaps a little bit more of the beneficial results coming from your services, and you could present your case more effectively.

DR. MORGAN: Yes, sir.

COMMISSIONER FIRESTONE: However, you have done so very effectively and comprehensively, as we can see from the very substantial and well-documented briefs.

If we may now look at Paragraph 11 on Page S-3, in which you recommend that in order: "To encourage post-graduate study, the Income Tax Act should be amended to provide for the deduction for tax purposes, of the expenses and tuition of approved post-graduate





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Morgan 10503

training for members of the healing arts". Dr. Morgan, who would do the approving?

DR. MORGAN: Mr. Commissioner, I believe that the approval here would be by the Department, on the recommendation of the respective healing art concerned. I believe that they would, if needs be, come to the chiropractic profession and ask us: "Which of your post-graduate courses do you consider would enter into this situation, and that you would approve as a suitable post-graduate study?" I think the same would have to be done for the medical profession, and dentistry, and so on.

COMMISSIONER FIRESTONE: In other words, it would be on the advice of the professional association concerned?

DR. MORGAN: I would suggest so.

COMMISSIONER FIRESTONE: May I now turn to Paragraph 21 on Page S-5, where you recommend that Canada should adopt a complete and comprehensive health care program, and you suggest that this program should be financed through taxation. I take it what you have in mind is a compulsory program that covers everybody?

DR. MORGAN: Mr. Commissioner, I think, if I may enlarge upon this particular aspect. It is our submission that the financing of health care should be in the category of a compulsory nature, and that it should cover all aspects of health care, including the actual services, the facilities, the educational expenses, the facilities for educating personnel, the preventive program, the research program, all expenses involved in



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4 health care, we submit, should be financed through  
5 taxation of some form. We are not prepared to state  
6 specifically what this form should be, but say that it  
7 is in that respect compulsory, and that all people in  
8 Canada would be supporting it. But we would recommend  
9 that the utilization of the services be on a voluntary  
10 basis, that a Canadian may choose to have the health care  
11 as a private patient, or under the plan, and we suggest  
12 that such a program isn't departing in any great way  
13 from established practice in Canada in that certain  
14 aspects of health services are currently financed on a  
15 compulsory basis, and I would point to insurance and  
16 hospital services. The erection of public hospitals  
17 through public funds, the facilities for educating and  
18 training personnel in the health fields are financed,  
19 in a way, on a compulsory basis through public funds.

20 COMMISSIONER FIRESTONE: When you say  
21 financed through taxation, who, or which level of Govern-  
22 ment, would collect those taxes to pay for the plan? Do  
23 you have in mind the Federal Government, Provincial Govern-  
24 ment, municipal governments, or a combination?

25 DR. MORGAN: I suggest that this will  
26 require a great deal of cooperation between the various  
27 levels of Government, but what I think would be ideal if  
28 it could be worked out, would be a program similar to  
29 the program that we have enjoyed in Canada on this tax-  
30 sharing, tax rental basis at the income tax level, in  
which it would be collected by perhaps a national agency,  
and distributed on a per capita basis perhaps to the  
Provinces. This pre-supposes that all Provinces would  
join the plan.







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These are problems that may or may not arise. If it were not adopted on a national level then it would require some form of provincial taxation so that each province could maintain its own program as the Constitution provides for the field of health.

COMMISSIONER FIRESTONE: Would you then visualize a provincially-operated and administered program in part paid from provincial financial resources, in part paid from financial assistance from the Federal Government; is that the sort of scheme you envisage? Or do you visualize a national plan administered by a national government? What do you envisage?

DR. MORGAN: I realize the difficulties. I think the simplest form would be a national plan financed initially but with the provincial jurisdiction in the field of health care it becomes more complicated and provinces are jealous of their provincial autonomy and I believe rightly so. I believe there will be some problems arise and there would needs be a great deal of understanding and co-operation between all concerned at all governmental levels.

COMMISSIONER FIRESTONE: Would you accept the application of the principles which presently underlie the hospital insurance program which is, as you know, provincially-administered, in part provincially paid for and in part paid for out of federal contribution, financial grants? Would you accept the application of that principle to the payment and coverage of all other health care services including hospital services, which are already covered?



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arise. It is not accepted on a national level that it would require some form of national taxation so that each province could maintain its own program as the Constitution provides for the kind of a split.

CONSTITUTIONAL PROVISIONS. Would you then

maintain a provincial system and administered program in part paid from provincial financial resources, in part paid from financial assistance from the Federal Government, as that is the way of some of our countries? Or do you visualize a national plan administered by a national Government, with no provincial

W. H. HARRIS: Regarding the difficulties.

I think the simplest form would be a national plan financed initially not with the provincial jurisdiction in the field of health care it becomes more complicated and provinces are jealous of their provincial autonomy and I believe rightly so. I believe there will be some problems arise and there would need be a great deal of understanding and co-operation between all concerned at

all governmental levels.

W. H. HARRIS: I believe. Would you

accept the possibility of the provinces which presently underlie the health insurance program which is, as you know, provincially-administered, in part provincially paid for and in part paid for out of federal contribution financial grants. Would you accept the application of that principle to the present and future of all health care services including hospitals, clinics, and are already covered?



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DR. MORGAN: I believe this worked out satisfactorily. I know there are criticisms of the program, particularly the financial aspects of it, but I believe the principles could well be adopted in this program.

COMMISSIONER FIRESTONE: And would you so recommend? If you have no views on it, please say so.

DR. MORGAN: I would say we are not prepared to recommend that as the most desirable method. I think it may be acceptable.

COMMISSIONER FIRESTONE: My last point relates to your paragraph 24 in which you suggest that the program might be developed in stages and you visualize the first stage to include children under 18 years and those over that age who are enrolled in institutions of learning.

Then you mention other groups. Now, on page 72, in paragraph 175, you say, and I quote:

"In our opinion it is desirable to extend the benefits and provisions of comprehensive health care program including chiropractic, to all Canadians, at the earliest possible time."

I would like to envisage what you mean by "the earliest possible time." Are you envisaging, to start off with, a limited program and within a given number of years, to achieve complete coverage for everybody; is that your plan?







Morgan

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DR. MORGAN: In essence. If I might speak on this, it is our suggestion that the program will, of necessity, start on a limited basis, not perhaps as limited as it may seem but we suggest the facilities and the personnel of all of the branches of the healing arts in Canada would not be adequate to immediately care for all Canadians covered under a national health program and that the development of the program should proceed in stages.

With the development of facilities and personnel to render health services, this must be augmented, and as those programs become effective and productive then the service should be made available to an increasing percentage of the population.

We suggest that the program should start with children whom we submit are one of our most important considerations and that the people who are, through financial circumstances, unable to provide for their own health services, and as quickly as possible, all Canadians.

COMMISSIONER FIRESTONE: Would you give us an indication of the time in which you would hope Canada might achieve this overall and complete program, proceeding in stages? Are you thinking in terms of 5 or 10 years? What is your concept of "as quickly as possible"?

DR. MORGAN: I would hope, of course, depending on when the program starts, 5 years, perhaps, might be an optimistic outlook but we would look for that.

COMMISSIONER FIRESTONE: That would be





Morgan

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a target one would aim at?

DR. MORGAN: Yes.

COMMISSIONER STRACHAN: If I might refer to page S1, paragraph 5, the sentence in the middle of that paragraph stating:

"We recognize that chiropractic is not indicated for all conditions..."

That is a very admirable admission and you go on to state:

"...under these circumstances we are pleased to refer these patients to qualified members of the appropriate healing art."

My impression is that this is possibly one of the greatest accusations against your profession.

My question to you is, Dean Macmillan and to the national and provincial groups in general, what is done in the teaching to impress upon the members of your profession that this should be observed? May I add another question to that? Have you any idea of the number of patients who are referred by your profession to qualify as members of the appropriate healing art when you do not consider yourself adequate to deal with them?

DEAN MACMILLAN: To answer your first question, our students are taught a very comprehensive course which would allow them, in their judgment, to realize the limitations of the service that they may have to offer under any given set of findings on the patient concerned, with their understanding of the broad







Macmillan

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concept of the human body and its frailties, they would be able to form their own opinion and inform the patient according to the needs of that person.

Secondly, the second part of your question, it would be most difficult to say in the course of a day's practice, depending upon the volume of patient flow through that office, how many persons are thereby under these circumstances, a mistake, an accidental fall, depicted fracture by x-ray examination would be referred.

Many may occur on more than one occasion in one day should there be a field day or a sports day which may not occur again for a number of weeks, it may not occur again that year. The various pathological changes that occur in the human body would be depicted in the chiropractor's office; it would be most difficult to know in numbers those people who might present themselves in the course of a week who then would be referred. I cannot answer by numerical figures the second part of your question.

DR. SUTHERLAND: May I add a comment in this regard? In 1956 the Canadian Chiropractic Association conducted a survey of its membership to determine how many members did refer cases to medical practitioners and out of the 293 replies that we received, 97.6% reported that they had referred patients to medical practitioners as indicated. There was no question to ask how many; all I can tell you is that 97% reported that they had done this.

COMMISSIONER BALTZAN: Gentlemen, I



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Medical

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concept of the human body and its facilities, they would be able to form their own opinion and in some the patient according to the needs of that person.

Secondly, the second part of your

question, it would be most difficult to say in the course of a day's practice, depending upon the volume of patient flow through that office, how many persons are thereby under these circumstances, a mistake, an accidental fall, depicted procedure by x-ray examination would be returned.

Many may occur in more than one session in one day should there be a third day on a sports day which may not occur again for a number of weeks, it may not occur again that year. The various patients great changes that occur in the human body would be depicted in the anthropologist's office; it would be most difficult to know in numbers those people who are present themselves in the course of a week who would be returned. I cannot answer by numerical figures the second part of your question.

Dr. Thompson: May I add a comment in this regard? In 1935 the Canadian Rheumatoid Association then conducted a survey of its membership to determine how many members did refer cases to medical practitioners and out of the 113 replies that we received, it is reported that they had referred patients to radiologists as indicated. There was no question of ask how many; all I can tell you is that 113 reported that they had done this.

CONFIDENTIAL REPORT: See form,



Macmillan

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want to begin by first assuring you of my very keen interest in your claims and in your recommendations. All that we seek here is information and enlightenment upon some areas that are not clear to us.

I would begin with perhaps a question directed to the Dean; on page S4(1), you say:

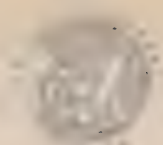
"Complete recognition as a private, non-profit, professional educational institution, serving the needs of all Canada and offering education opportunities as well to students from foreign countries" is required.

What I want to know is why the complete recognition? Do you mean academic; do you mean recognition of an academic nature, complete recognition by the public? Would you please explain what you mean by complete recognition?

DEAN MACMILLAN: Complete recognition would allow us to be academically recognized and that is by way of eventual possible affiliation with the university. In that way the grades obtained by our students in our college will be transferable to any institution of higher learning and be applied towards the furtherance of their education in any course. Do I make that clear?

COMMISSIONER BALTZAN: Yes, that is what I wanted and I know elsewhere here you have made approaches to universities in relation to that sort of recognition or establishing faculties; what have been the results?





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William

All that we ask here is information and enlightenment upon so a sharp and clear line to me.

I would begin with perhaps a question

directed to the Dean; on page 24(1), you say:

"Complete recognition as a private, non-profit, professional educational institution, serving the needs of all Canada and offering education opportunities as well to students from foreign countries" is required. That I need to know is why the

complete recognition? Do you mean academic? do you mean recognition of an academic nature, complete recognition by the public? Would you please explain what you mean by complete recognition?

would allow us to be academically recognized and that is by way of eventual possible affiliation with the university. In that way the grades obtained by our students in our college will be transferable to any institution of higher learning and be applied towards the fulfillment of their education in any course. I

I make that clear?

QUESTIONS: (1) Now, that is

what I wanted and I know elsewhere where you have made reference to universities in relation to that sort of recognition or establishment. I think what have been



Macmillan

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DEAN MACMILLAN: We have not, in the Province of Ontario, or any other province of Canada, made overtures to any university or college other than in the Province of Manitoba. Now, if we could hear from the representative for Manitoba with regard to what they accomplished?

DR. COLLETT: Last Fall we approached the University of Manitoba and spoke to Dr. Saunderson as to the question of affiliating with the university. His reply was primarily for economic reasons he could not see this coming up within five years.

COMMISSIONER BALTZAN: So you emphasize the main obstacle there was a question of finance?

DR. COLLETT: He emphasized this, yes.

COMMISSIONER BALTZAN: And nothing as to the curriculum and your preparation and so on that is built into other topics of education; that question did not come up?

DR. COLLETT: We did not get that far into the negotiations.

COMMISSIONER BALTZAN: Thank you. You say you have difficulties about the local basis; New Brunswick is recognized or given local status and I gather Nova Scotia has not; am I correct?

DR. MORGAN: That is right.

COMMISSIONER BALTZAN: Could we know something of the reason? I think there is one area, Quebec, that is not represented here and I cannot ask anybody.

DR. MORGAN: We do have a representative from Quebec. If I could have Dr. Robichaud speak briefly



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on the difference.

DR. ROBICHAUD: Mr. Chairman, to the chair, Mr. Commissioners, in Nova Scotia they have tried four times, gone before the legislation. I have just appeared this past month three times before our own legislation on a new Workmen's Compensation Act.

There is in Nova Scotia family compact of members in the legislative which know how they will vote before the bill comes before the session.

COMMISSIONER BALTZAN: I don't want anything combined with political. Were there any specific professional reasons for not entertaining the application?

DR. ROBICHAUD: No professional reasons whatsoever.

COMMISSIONER BALTZAN: That is all that I wanted. In the Province of Saskatchewan you are associated with the University in relation to examination. Is that satisfactory to you or have you approached them also in relation to the question of affiliation?

DR. MORGAN: Mr. Commissioner, the situation in Saskatchewan as it presently exists is the Examining Board for the Province of Saskatchewan is a composite board with representation from the University of Saskatchewan in the basic science subjects and representation from the Chiropractic profession in the chiropractic subjects. It has been working quite satisfactorily.

THE CHAIRMAN: On the same basis as any other profession in the provinces?







Morgan

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3 DR. MORGAN: Right. Yes Mr. Chairman.

4 COMMISSIONER BALTZAN: That is working  
5 out satisfactorily, as far as your Association is  
6 concerned?

7 DR. MORGAN: Yes.

8 COMMISSIONER BALTZAN: The same sort  
9 of experience in the other Provinces where your people  
10 are examined for licence in association or under the  
11 umbrella of the University in that Province?

12 DR. MORGAN: To my knowledge there is  
13 no other Province in which it is conducted in this way.  
14 May I add concerning the Saskatchewan situation, Mr.  
15 Commissioner, there were some difficulties initially.

16 For several years there were no new  
17 candidates, no graduates coming into Saskatchewan and  
18 this program wasn't being utilized. Since 1949 there  
19 have been a number of new chiropractors come into  
20 Saskatchewan and at the outset there were some problems  
21 that had to be ironed out.

22 In recent years, to my knowledge, it  
23 is working quite satisfactorily.

24 COMMISSIONER BALTZAN: In the same area  
25 in those provinces where you have not got legal status,  
26 or licence, is there a per contra prohibition so that one  
27 cannot practise in your field in that Province, or you  
28 practise, shall we say, without a licence? How does  
29 it operate in those areas?

30 DR. MORGAN: Perhaps if I can ask  
Dr. Gaudet to try to answer this. He has been practising  
in Quebec for many years.





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3 DR. GAUDET: Yes Mr. Commissioner,  
4 we practise without a licence. However, I would say  
5 that we are more or less supported by public opinion,  
6 therefore, most of the chiropractors do not have any  
7 trouble at all.

8 On the other hand, we have our own  
9 Association and we conduct ourselves, as far as Code  
10 of Ethics, and so on, as if we were licensed and this  
11 has given us a very favourable public opinion.

12 THE CHAIRMAN: Dr. Gaudet, you have  
13 a sort of incorporation under one of the charitable  
14 societies or some legislative basis in Quebec have you  
15 not?

16 DR. GAUDET: No, Mr. President, we  
17 only have a charter that gives us the right to organize  
18 ourselves as an Association.

19 THE CHAIRMAN: I thought we were told  
20 in Montreal you had sort of an arrangement with the  
21 medical profession, sort of an unofficial arrangement?

22 DR. GAUDET: Yes, that might be a  
23 tacit arrangement.

24 THE CHAIRMAN: Whether it might be: Is  
25 that the fact?

26 DR. GAUDET: No, it is not the fact  
27 Mr. President.

28 THE CHAIRMAN: All right, it is not.  
29 Didn't some of your members appear before us in Montreal?

30 DR. MORGAN: No Mr. Chairman. This  
is our first appearance before the Commission.

THE CHAIRMAN: It was from the College







Gaudet

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4 of Physicians and Surgeons that we were informed there  
5 was sort of a charter letter in existence under which  
6 the practice of chiropractic in Quebec was acquiesced  
7 in by the College of Physicians and Surgeons. You are  
8 not aware of that Dr. Gaudet?

9 DR. GAUDET: I never heard of it.

10 THE CHAIRMAN: Very well.

11 COMMISSIONER BALTZAN: Gentlemen, we  
12 are running into a lot of names of kinds of practice,  
13 chiropractic practice, physiotherapist, occupational  
14 therapist, including also physical medicine. I am not  
15 trying to compare them, I am just trying to collect  
16 them.

17 All these are concerned with physical  
18 diagnosis and physical treatment, except, say, the  
19 physiotherapists and occupational therapists. In  
20 chiropractic practice of physical medicine you are  
21 concerned both with diagnosis and treatment and this is  
22 on a physical basis. Am I right?

23 DR. MORGAN: Yes sir.

24 COMMISSIONER BALTZAN: Along the  
25 lines of your own philosophy.

26 DR. MORGAN: Right.

27 COMMISSIONER BALTZAN: Now then,  
28 there seems to be a new term mentioned called a physia-  
29 trist that I think so far is only limited to those people  
30 who are in physical medicine as a branch of the practice  
of medicine. Would your category come under the broad  
term of physiatrist where you are dealing with physical  
conditions and applying physical methods for their relief?



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4 DR. MORGAN: I really don't think so  
5 Mr. Commissioner for this reason: The physiatrist is,  
6 firstly, a medical doctor, graduate physician and he is  
7 specializing in the field of physical medicine under  
8 this terminology and his approach to the condition, to  
9 the patient's condition is different in principle. It's  
also different in actual procedure in many respects.

10 The basic difference, I think, is  
11 one of philosophy of the chiropractor's profession as  
12 compared with the philosophy of the practice of medicine.

13 The philosophy which is the motivating  
14 impulse behind our profession is that the practice of  
15 chiropractic is not limited, let us say, to the field  
16 that the physiatrist's limits his practice to in this  
17 respect that in my opinion the physiatrist is practising  
18 in the field of spinal injuries using physical means  
19 in addition to manipulation without the concept of the  
20 relationship between that spinal problem and other  
21 related conditions. Whereas, in chiropractic, granted  
22 a large percentage of our work load is in the nature  
23 of cases of spinal injuries, but a growing percentage of  
24 our work load is in conditions of constitutional nature  
although there may or may not be any local indication  
of spinal injury.

25 COMMISSIONER BALTZAN: When you say  
26 "spinal injury" do you mean those related to the nervous  
27 system, the nervous tract or are you thinking of terms  
of say the skeletal system?

28 DR. MORGAN: The traumatic damage to  
29 the skeletal system.  
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4 COMMISSIONER BALTZAN: Interfering  
5 with ---

6 DR. MORGAN: With the nervous system.

7 COMMISSIONER BALTZAN: Just one thing,  
8 you have added in here an abstract from the Canadian  
9 Medical Association, which I think is quite a compliment  
10 on both sides. It was by Dr. W.B. Parsons and Dr.  
11 J.D.A. Cumming, Red Deer Alberta "Manipulation in Back  
12 Pain". Under what category does that come under  
13 chiropractic procedures or come under physical pro-  
14 cedures, physiotherapy? We are interested to learn  
15 how you are operating.

16 DR. MORGAN: This is an appendix  
17 explaining the section Chiropractic and medicine contained  
18 in the brief. I would ask Dr. Sutherland if he would  
19 expand on that.

20 DR. SUTHERLAND: I would say Mr.  
21 Chairman, Dr. Baltzan, the article to which you refer  
22 appeared in the Medical Journal of 1958 and is an  
23 indication to us of the increasing importance being  
24 attached to spinal manipulated procedures by certain  
25 members of the medical profession. Some of them have  
26 studied these procedures in detail and have come up  
27 with some extremely favourable reports in spite of what  
28 we might refer to as the overall opposition to this  
29 procedure which we generally experience.

30 I know Dr. Parsons addressed the  
Canadian Medical Association convention in Banff in  
1960 where he outlined his work and he said, before  
his colleagues, that he realized that to admit to the





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3 manipulation of the spine was to seek the brand of  
4 charlatan from his colleagues so that we feel this is  
5 not generally accepted in the field of medicine although  
6 many of their specialists are showing an interest in it.

7 We feel the outline in this article  
8 is -- I was going to say imitation -- it's an effort  
9 to duplicate our work because of the success they have  
10 seen in it.

11 THE CHAIRMAN: The doctors are  
12 smartening up?

13 DR. SUTHERLAND: Perhaps I should just  
14 quote one sentence.

15 COMMISSIONER BALTZAN: I don't mind  
16 if you say yes.

17 DR. SUTHERLAND: One sentence here sir  
18 "The reason we took up manipulation was an interest in  
19 back ache, with the early discovery that many patients  
20 who failed to respond to routine medical treatment went  
21 to a manipulator and received immediate relief. This  
22 discovery was followed by acceptance of the classic  
23 advice 'if you can't whip 'em, join 'em' at least to  
24 the extent of borrowing their technique". We took that  
25 as quite a compliment sir.

26 COMMISSIONER BALTZAN: Then you would  
27 call that a re re-discovery. In relation to your  
28 examinations and taking of history, and then the final  
29 question, just a quickie, how do you put down, what term  
30 do you use for your various diagnosis. I can easily  
see those things immediately referable to the spine and  
the areas within the spine, those things you connect as





manipulation of the spine was to ease the pressure  
which was on his collar, and as that was all this is  
not generally accepted in the field of medicine although  
many of us who speak of it are showing an interest in it.  
We feel a outline in this article  
is -- I was going to say something -- it's an effort  
to duplicate our work because of the success they have  
seen in it.

THE CHAIRMAN: The doctor was  
satisfied and  
DR. WATKINS: I should just  
more one sentence.  
CONVULSIONS AND THE  
it was very good.

DR. WATKINS: The treatment was very  
"The reason we took up manipulation was an interest in  
back ache, with the early discovery that many patients  
who failed to respond to routine medical treatment went  
to a manipulation and received immediate relief. This  
discovery was followed by acceptance of the classical  
advice that we don't want to go back to the old  
the extent of bone and tissue manipulation." It took what  
as with a combination of

call that a re-disclosure. In relation to your  
examination and the use of history, and then the final  
question, just a second, how do you put down, what you  
to use the word various of angles? I can easily  
see these things immediately related to the spine and  
the stress within the spine, those things you cannot see



Sutherland ..... 10519

emanating from the spine perhaps affecting the head or any other things. What sort of classical diagnosis do you give?

DR. SUTHERLAND: I would say that we use the usual medical diagnostic terms realizing that there is a primary, a secondary factor here for us. For example, migraine headache I believe one of the indications is it's a circulatory disturbance in the head.

I feel this is correct and that the circulatory disturbance may be caused by nerve irritation in the spine so that our diagnosis might be migraine caused by, might be, vertebral subluxation.

COMMISSIONER BALTZAN: You do resort to the classical nomenclature as far as possible?

DR. SUTHERLAND: Yes sir.  
COMMISSIONER BALTZAN: With your own modifications as to the etymology?

DR. SUTHERLAND: Yes.

COMMISSIONER BALTZAN: Lastly, you want to be included in the consideration and anything that may come up under a plan so that you may render service, is that right? I haven't got the exact place.



examination from the spine perhaps affecting the head or  
 any other thing. What sort of classical of course  
 do you give?

MR. S. L. L. I would say that we  
 use the usual medical diet but terms realizing that  
 there is a difficulty, a necessary factor here too as  
 for some of the things mentioned. I believe one of the  
 indications is the a characteristic disturbance in the  
 feet.

I feel this is correct and that the  
 other factors disturbance can be caused by the limitation  
 in the spine so that our diagnosis might be maintained  
 caused by, right is, vertebral subluxation.  
 COMMISSIONER L. L. L. You do resist

to the classical nomenclature as far as possible?  
 DR. L. L. L. Yes sir.  
 COMMISSIONER L. L. L. With your own modifications as to  
 the classical?

COMMISSIONER L. L. L. Yes, sir.  
 What to be retained in the consideration of the spine?  
 May come up under a view so that you can answer likewise,  
 is that right? I don't want too exact place.



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4 DR. MORGAN: Yes, that is in the  
5 brief.

6 COMMISSIONER BALTZAN: In what way  
7 does your science feel it can contribute to that aspect  
8 of this very large problem, sometimes I think it is  
9 made too large, to seem too large, so it makes many  
10 Canadians feel perhaps they are not normal.

11 DR. MORGAN: I wonder if I could ask  
12 Dr. Macmillan to answer this or delegate someone on the  
13 Faculty of the College.

14 DR. MACMILLAN: May we hear from Dr.  
15 Greenshields.

16 DR. GREENSHIELDS: We base this partly  
17 on the research of our profession and on the fact we now  
18 at the present time have, at least, one chiropractic  
19 mental institution that has been carrying on this work  
20 for a number of years and the results obtained have been  
21 very favourable in that regard, also due to the fact that  
22 many emotionally disturbed people who may not be psychotic  
23 form part of our every-day professional practice, and  
24 it has been our experience that the actual physical  
25 condition has a definite mental effect and our profession  
26 has been successful in dealing with those, all other  
27 factors concerned.

28 COMMISSIONER BALTZAN: What I would  
29 like to know, within your frame of reference have you a  
30 special methodology other than those things we have been  
talking about, chemotherapy and psychotherapy and others,  
within the field of your science and philosophy that  
perhaps the rest of us should learn about?







Greenshields 10521

DR. GREENSHIELDS: Yes, sir, I think that the spinal column has a relation upon the head and upon the brain and its activity is the same as it has upon structures in, say, the arm or organs of the body.

COMMISSIONER BALTZAN: That is exactly etymology, methodology, outside of the manipulation is there any other form of approach to the problem of mental illness?

DR. GREENSHIELDS: In these institutions?

COMMISSIONER BALTZAN: That is your domain.

DR. GREENSHIELDS: The difference of the spinal manipulation is the main difference, sir, that is correct.

COMMISSIONER BALTZAN: In this school you have -- is it a school or hospital you have?

DR. GREENSHIELDS: Chiropractic hospital, yes, Clearview Chiropractic Sanatorium.

COMMISSIONER BALTZAN: Sanatorium.

DR. GREENSHIELDS: Yes.

COMMISSIONER BALTZAN: Could we sometimes get some statistical results of both the procedures and the results, types of individuals common to that?

DR. GREENSHIELDS: I think I could supply it.

DR. MORGAN: Excuse me, some of these statistics are contained in the brief. I apologize for their meagre extent, but they are contained to a degree in Paragraph 63 and carry on for a few subsequent paragraphs. They are not extensive yet. We haven't as yet



DR. GREGG: Yes, I think

that the spinal column has a relation upon the brain and upon the brain and its activity is the same as it has upon structures in, say, the organs of the body. That is, exactly

everybody, methodologically, even in the manipulation is there any other form of approach to the problem of mental illness?

DR. GREGG: In these institutions?

DR. GREGG: That is your

question

DR. GREGG: The difference of

the spinal manipulation is the real difference, and, that is correct.

DR. GREGG: In this school

you have -- is it a school or hospital you have?

Hospital, yes, Cleveland Psychiatric Sanatorium.

DR. GREGG: Yes.

DR. GREGG: Could we have

times get some statistical results of the procedures and the results, cases of individuals known to that?

DR. GREGG: I think I could

supply it.

Statistics are collected in the office, I suppose, in their various extent, but they are confined to a degree in the sense of the and some of the subsequent phases. That is not entirely a fact, but I think it is.



Morgan 10522

been able to conduct a survey within the profession that would be of real use to us in obtaining reliable statistics in the care and management of mental problems.

COMMISSIONER BALTZAN: Thank you very much. If you could supply us with that on a formal basis, with statistical results, we would be pleased.

DR. MORGAN: We will try.

DR. SUTHERLAND: May I refer in our list of exhibits to Page 73, Exhibit 9, nervous and mental cases under chiropractic care. It is a survey from the United States. I would also refer you to Exhibit 10, Home Care for the Emotionally Ill by Dr. Schwartz who is a member of our Association in the United States.

COMMISSIONER BALTZAN: Would you repeat that again?

DR. SUTHERLAND: Page 73, Exhibit No. 9 and 10.

COMMISSIONER BALTZAN: I have been informed I haven't got that list as yet.

DR. SUTHERLAND: We have additional copies if you wish.

COMMISSIONER BALTZAN: Anything you have will be of interest to the Commission. Thank you.

THE CHAIRMAN: Dr. Morgan, I just want to make a clarification in connection with S-5 of your national brief, Paragraph 21. We want to recommend, so forth and etcetera, a complete program including services etcetera, should be financed through taxation. In our opinion a plan in which health care is dependent on the payment of premiums is doomed to failure. We may take it







Morgan 10523

you are unalterably opposed to a premium or part premium system.

DR. MORGAN: I don't know we could go that far. We are opposed to a program of this nature being based on a premium procedure. If I may enlarge on that point, Mr. Chairman?

THE CHAIRMAN: All right.

DR. MORGAN: The experience in the Province of British Columbia in the implementation of the BCHIS Hospital Service in the early 1950's was such -- it was implemented on the principle of premium payment and their experience was to the effect that on far too many occasions people requiring hospitalization appeared at the doors of the hospitals and hadn't paid their premium and weren't then entitled to hospitalization. This happened to such an extent the program was falling in disrepute. In their wisdom the Government changed their program of financing to one of taxation by increasing the sales tax and that no longer is the program. All people in the Province are covered by the hospital insurance service. We suggest that the same thing will still happen in a national health care program, those who most require the service will not have paid the premium when the time comes to require this service.

THE CHAIRMAN: You think a province like Saskatchewan who has the premium program are backward people?

DR. MORGAN: Mr. Chairman, you have put me on the spot.

THE CHAIRMAN: You put yourself on the spot when you got so generous in your praise of one governmental action.





Morgan 10524

DR. MORGAN: We suggest in view of the experience therein and our considered opinion of what would happen that this program through a premium program would fail.

THE CHAIRMAN: On 24 you suggest there should be delay in the implementation of the program because you don't think the personnel is available and so forth. Do you see a substantial increase in the demand merely through the inauguration of the program that you advocate?

DR. MORGAN: We suggest that there will be an increase. How substantial, we can't say specifically.

THE CHAIRMAN: Apart from population increase, an increase in the present demand.

DR. MORGAN: Yes, we submit so.

THE CHAIRMAN: Why?

DR. MORGAN: There are people in Canada who presently are not seeking health care that they should have through lack of funds with which to pay for this service. I believe a percentage of Canadians are too proud to accept charity even though it is available. It is not a matter of care being denied. It is a matter of them refusing to take care when they can't afford to pay for it.

THE CHAIRMAN: I notice that several of the Provincial briefs, if there is an explanation for it I would be glad to have it -- start with British Columbia, you associate yourself with the national brief and approve of it. Going through the provinces some do







Sutherland 10525

and some don't. When you come to Ontario they make no reference to it. I was wondering if there is any significance to the fact several of the provinces specifically endorse the national brief and Ontario does not.

DR. SUTHERLAND: Mr. Chairman, the Ontario Chiropractic Association does endorse the national brief of the Canadian Association.

THE CHAIRMAN: You say so now. You will appreciate you didn't say it in your summary.

DR. SUTHERLAND: Yes, sir, there is a slight difference of opinion with regard to priorities, which you will note. I don't personally think it is a serious matter, but there is a slight difference. Our priorities suggest acute and chronic cases should receive chiropractic care at the beginning of the program. The Canadian brief suggests that manpower would not permit us to handle this situation. That is an honest difference of opinion, but we do support the Canadian brief.

THE CHAIRMAN: Dr. Gaudet, you have no brief as such. Are you here today to speak for your group in the Province of Quebec or are you here as an individual?

DR. GAUDET: No, I have been sent here as a representative of the Province of Quebec, and the reason why we didn't present a brief is that we have a bill at the present time before the Legislature which will come up within one or two weeks.

THE CHAIRMAN: That is a good enough reason. So far as putting in a brief, that is entirely your position. We have no objection to people not putting



and some can't. When you come to Canada they have to  
reference to it. I was wondering if there is any signifi-  
cance to the fact several of the provinces specifically  
support the national right and Ontario does not.

Ontario Civil Service Association does not use the national  
symbol of the Canadian Association.

Mr. [Name]: You say so now. You  
will explain if you didn't say it in your summary.

Mr. [Name]: Yes, sir, there is

a slight difference of opinion with regard to priorities,  
but there is a slight difference.

Our political groups would and our laws should

relative differences as the beginning of the program.

The Canadian press suggests that whatever might not permit

us to handle this situation. That is an honest difference

of opinion, but we do support the Canadian press.

Mr. [Name]: Yes, sir, you have

no other way to speak for your

group in the future or to speak for you here as an

individual.

Mr. [Name]: No, I have been seen

here as a representative of the Province of Ontario, and

the reason why we didn't present a brief is that we have

a bill at the present time before the Legislature which

will cover the whole of the subject.

Mr. [Name]: That is a fact, enough

reason. On the other hand, it is entirely

you position. We have no objection if people not want



Gaudet 10526

in briefs. This has happened in other spheres.

DR. GAUDET: However, with your permission I would say that the members of the College of Chiropractic in Quebec are endorsing the contents of the brief presented this morning by C.C.A.

THE CHAIRMAN: That you are thinking there should be in Canada a compulsory medical service plan which would include chiropractic treatments based on taxation and not premiums?

DR. GAUDET : Yes.

THE CHAIRMAN: Thank you very much.

DR. MORGAN: Could we clarify that?

THE CHAIRMAN: Could you clarify Quebec's position?

DR. MORGAN: May I suggest to Quebec that perhaps they would be interested in clarifying their agreement to the statement you made.

THE CHAIRMAN: I wouldn't want anyone to leave the wrong impression of what he was agreeing to.

DR. MORGAN: That would be the use of the word "compulsory" insofar as it was described as compulsory as far as financing is concerned, but not compulsory as far as utilization.

THE CHAIRMAN: Everybody would have the privilege of paying for the premium, but would not have to take advantage of it.

DR. MORGAN: Right.

THE CHAIRMAN: That is how it was expressed.

DR. MORGAN: Thank you.







Morgan 10527

THE CHAIRMAN: Thank you very much, gentlemen. Yes, Dr. Robichaud, I am sorry I didn't see you.

DR. ROBICHAUD: Yes, Mr. Chairman, may I add here to what the President said, that New Brunswick has now abandoned the payment of premiums. That is how Premier Robichaud got in.

THE CHAIRMAN: We are not concerned with political questions, Mr. Robichaud.

DR. ROBICHAUD: That is not political.

THE CHAIRMAN: You say that is how he got in. Don't tell me that was not a political statement.

DR. MORGAN: Mr. Chairman, I have here the brief referred to earlier of the Honourable Robert J. Brookes, Minister of Veterans' Affairs. I will be glad to leave that with you.

THE CHAIRMAN: Dr. Morgan, I noted here, in Saskatchewan, on Page S number 9, that the new health care initiated in Saskatchewan is likely to provide a comprehensive, and so forth, and that chiropractic is expected to be included. Is that one of the items referred to in the list of matters to be covered, or is it named in the Act?

DR. MORGAN: Mr. Chairman, I have a correspondence from Saskatchewan that arrived only yesterday, and it is to this effect...

THE CHAIRMAN: They are going to convene legislature and change the Act?

DR. MORGAN: That is not apparently what is contained in this letter.





Morgan 10528

THE CHAIRMAN: I don't know how anyone is by a letter going to change the specific wording of the Act that says it will be covering A, B, C, D, E and F. They, as I recall, don't mention chiropractic services.

DR. MORGAN: Would you be interested in hearing the contents of this on this particular matter?

THE CHAIRMAN: No, I think there is too much involved in Saskatchewan. I was wondering if it was a matter of amendment to the Act.

DR. MORGAN: No.

On behalf of the members of the Chiropractic Profession, please accept our sincere thanks for your kind attention to this presentation, and the fact you have gone well into your lunch hour is very much appreciated. We express our thanks to the Chairman and Members of the Commission and to their Secretary for all the cooperation we received.

THE CHAIRMAN: We are very grateful to you gentlemen for the presentation. It is very much indicated by the nature of your brief and from the large attendance here this morning that you are very deeply interested in this, and we are also. We thank you for your submission.

DR. MORGAN: Thank you.

THE CHAIRMAN: We will adjourn until two p.m.

---Luncheon Adjournment.





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Yours faithfully,  
[Signature]

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--- On resuming at 2 p.m.

THE SECRETARY: Mr. Chairman, the next brief is that of the Communist Party of Canada, Exhibit 288, and Mrs. Clark will present the gentleman with her and also summarize the brief.

--- EXHIBIT NO. 288: Submission of the Communist Party of Canada.

SUBMISSION OF THE COMMUNIST PARTY OF CANADA

Appearances: Mrs. P. Clarke  
Mr. A. Dewhurst

MRS. CLARKE: The gentleman with me is Mr. Dewhurst and we appreciate the opportunity to present our views on a health care plan to this Royal Commission.

We feel that experience has shown that Canadians have welcomed, in fact demanded, that the federal and provincial governments assume responsibility, as a social need, for old-age, mother's, blind and other pensions, workmen's compensation, unemployment insurance, family allowances and so on, and that they also want a comprehensive national health plan.

That what already exists in Canada in relation to government activity in the field of preventive medicine and so on bears out the extent to which such measures are of assistance in helping the health of the Canadian people.

We feel that a comprehensive national health plan is a right of every Canadian, that by the signing of the Declaration of Human Rights, which was



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3 adopted by the United Nations in December of 1948, which  
4 right is the right to health protection; in effect the  
5 Government committed this country to the implementation  
6 of a health plan, and what is needed now is to go  
7 beyond the declaration of that right to the implementation  
8 of the right as a government responsibility.

9 Our Party holds the view that morally  
10 and economically Canada can ill afford to delay any  
11 longer the implementation of a national health plan.  
12 Our proposition is that such a health plan should be  
13 comprehensive, under a central administration. We also  
14 feel that it should include dental care, medicines,  
15 drugs and corrective devices on prescription, and home  
16 care.

17 We feel that our country, which is a  
18 very rich country, could well afford such an all-inclu-  
19 sive national health plan. At this point in world  
20 history Canada ranks 17th of the countries in the world,  
21 according to a recent survey of the International Labour  
22 Office, in the percent of national income which is paid  
23 to social health and welfare.

24 This is a figure which could very  
25 easily be increased, and would be of tremendous benefit  
26 to the Canadian people, and should be increased by the  
27 extension and implementation of a national health plan.

28 Along with the payment for health in  
29 this country there is the tremendous loss to people as a  
30 result of illness. We estimate that the total cost for  
the Canadian people without a national health plan,  
taking into account the cost of doctor, dental, drugs,







Clarke

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hospital care and so on, is somewhere over two billion dollars.

Broken down into cost per average family unit, we find that in 1957 the average urban family paid out the sum of \$224.30 for prepaid medical plans and direct payments for medical and dental services, drugs and appliances.

Making some adjustment for the changes in the price level since 1957, today we could assume that it is at least \$250.

In addition to this \$250 expended by the average urban family for health care, the sum of \$103 income loss by the average family through sickness. It means that the economic loss through sickness disability in 1961 amounted to \$373 per average family.

This economic cost of illness takes money from people who, in many cases, can ill afford it. And the need, we feel, of part of the revenue of the Federal Government, which in 1961 amounted to \$5,772,000,000 to be used in a much greater part for national health.

We feel, for example, that out of that budget in 1961 there was 1.7 billion spent for national defence. Today there are, in many fields, questions as to whether this is the most useful expenditure of our money in view of the conditions of the world today and the question of war being a much different thing, and the possibilities of thermo-nuclear war.

We feel, of course, that what is needed is disarmament, which will release sums for social and health needs.





Clarke

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The fact that such large amounts of money are found and spent in this way, we feel, means that it is also possible to find through the taxation powers of the Federal Government, the way to ensure an all-inclusive national health plan. We feel that the Federal Government, through agreement with the Provincial Governments, should establish a central authority that would be responsible for the administration of a comprehensive national health plan. That such administration should incorporate all the presently existing provincial and municipal health departments through mutual agreement. This would, we feel, ensure the best utilization of the large body of experience now resident in these departments and their personnel.

This, we feel, is quite important in order to ensure the establishment throughout the country of the highest possible medical standards and the provision of modern techniques of prevention and cure to all Canadians regardless of area and residence.

We feel that it should be a non-contributory comprehensive national health plan with the Federal Government bearing full responsibility for the health of the people. However, we are aware that it may not be possible at this time to enact a fully non-contributory comprehensive plan, and so we feel that as a step in that direction there should be a jointly financed federal and provincial plan, which would include, or could include, individual and family premiums.

We feel that perhaps the ratio of sharing the cost between province and the Federal







Clarke

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Government that could be 80% from federal and 20% from the provinces.

We feel that the family premiums and the individual premiums should be graduated, taking into account the income levels of the various groups, and should be based upon the income level of people.

In relation to drugs, we wish to point out that government ownership of the production of drugs and medicines would constitute a national service of considerable magnitude. If there was government-owned production, coupled with government-owned pharmacies connected with hospitals, clinics and sanatoria, for prescribed drugs, it would make possible considerable savings to the public purse.

If there was government production of drugs and medicines, and government-operated pharmacies, it would also facilitate the free distribution of prescribed drugs, or if not free distribution, at least, that drugs and medicine could be sold at cost. The Government is in, of course, all sorts of businesses already, including the liquor business, and could very easily go into the drug business.

We feel that in addition to the direct costs of illness there should be sick pay benefits as part of a comprehensive national health plan.





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4 We feel, in addition to the drug  
5 costs of illness there should be sick pay benefits as  
6 well as the comprehensive health plan, that the loss  
7 of income, the family suffering as the result of illness  
8 should be compensated through a payment percentage of  
9 the wages during the time that the person is sick.  
10 The principle of income maintenance through public plans,  
11 of course, has already been established in Canada with  
12 such things as Unemployment Insurance and Workmen's  
13 Compensation. Both of these, of course, recognize the  
14 principle of sustaining a certain income during the  
15 lost wage period. We feel that a worker incapacitated  
16 through sickness is just as much in need of income  
17 maintenance as a worker incapacitated through an  
18 occupational accident.

19 Then also, of course, we feel it is  
20 sound economics to pay sick benefits from the point  
21 of overall production and stimulation of the home market  
22 to keep the purchasing capability of the nation at the  
23 highest possible level. This is not just a humanitarian  
24 question.

25 Also we feel that in relation to the  
26 medical profession under a national health plan that  
27 in all the countries where health plans have been  
28 established the medical profession has adapted well to  
29 the new plan with, of course, certain difficulties.  
30 However, in the main they have done quite well. We feel  
that in Canada that an argument that says we should  
not have a national health plan because of some problem  
with the medical profession is just begging the question.







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3 There is no reason, we feel, why there should be any  
4 deterioration to the relationship between patients and  
5 doctors, on the contrary, relationships may improve  
6 if the problem of how to pay for the doctor was not,  
7 as is so often today, uppermost in the minds of the  
8 patients.

9 The nationalization of medical services  
10 has become necessary in the interests of the relationships  
11 between the patients and the medical profession. As far  
12 as the overwhelming majority of the patients are concerned  
13 their relationships to hospitals, surgical and all the  
14 forms of medical services is determined by the extreme  
15 and increasing costliness of these services. This  
16 decisive problem cannot be solved between individual  
17 patients and general practitioners. Great corporations,  
18 some of them monopolies, dominate the manufacture,  
19 distribution and prices of drugs, equipment, instruments  
20 and supplies. Hospitals and ancillary services are  
21 far removed from neighbourhood control. So far as the  
22 average patient is concerned this vast complex is quite  
23 impersonal. The dominate influence within it is that  
24 of big business and nationalization of medical services  
25 is necessary because that is the only way by which the  
26 principle of service according to need can replace the  
27 big business viewpoint which is now the dominant  
28 influence.

29 We maintain that the choice of doctor  
30 and service is a fundamental right of the individual.  
However, we are of the opinion that given mutual agreement  
as to the standards of service, methods and ways of payment







Clarke

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4 for services, and recognition of their concern for the  
5 doctor-patient relationship that the Canadian medical  
6 profession by and large will render high quality and  
7 unselfish service to their country under a national  
8 health plan. We believe the introduction of a free  
9 all-inclusive health plan will require vast expansion  
10 of trained medical personnel, nurses, and technicians  
11 and so on. There should be as part of the establishment  
12 of such a plan provision for scholarships and bursaries  
13 in order to give financial assistance to young people  
14 to train as doctors, nurses, technicians et cetera.  
15 There should be arrangements made for payment for  
16 doctors who work in isolated areas and so on.

17 It is our opinion that all medical  
18 personnel in all branches of medicine and health care  
19 should be on salary. Their rates of pay should be  
20 based on minimum levels in accordance with required  
21 skills, periodically negotiated between the personnel  
22 concerned and the health authority. Bonuses should be  
23 provided for special skills and locale of practise.  
24 It might not be immediately possible to achieve this  
25 desirable method of payment because the method of payment  
26 of the medical profession in Canada is fee-for-service  
27 although it should be pointed out that already one-third  
28 of Canadian doctors now practise at least partly on  
29 salary. One must also take into account the nurses and  
30 technicians and so on, they are, of course, almost  
completely on salary.

31 In conclusion we request that the  
32 Commission call for the institution of an all-inclusive







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4 national health plan as outlined in this submission.  
5 We wish to emphasize to the Commission that while we  
6 stand for a fully comprehensive plan, completely  
7 financed by the Federal Government, as a right of  
8 every Canadian and will continue to work for it until  
9 it has been attained, we also support those variations  
10 of ours and other proposals for a government administered  
11 health care which would open the way for the achievement  
12 of a non-contributory comprehensive national health  
13 plan.

14 THE CHAIRMAN: Thank you Mrs. Clarke.

15 COMMISSIONER McCUTCHEON: You have  
16 presented your views and we have had an opportunity to  
17 read your brief. I think your views have been presented  
18 very concisely and there is no question in my mind,  
19 at least, as to the position you are taking and from  
20 that point of view I have no questions to ask you.  
21 However, there is one question I would like to ask and  
22 that is, how many people do you represent, what is  
23 your membership?

24 MRS. CLARKE: Well, we do not release  
25 figures of our membership except at a time of year at  
26 which there is a renewal of membership in the organization  
27 which has not yet taken place this year. I would not  
28 want to give a figure which is not accurate because  
29 this is a presentation for a national organization and  
30 I myself do not know enough about the figures from  
across Canada to completely answer that.

COMMISSIONER McCUTCHEON: It is always  
helpful for us to have some idea of the number of persons







Clarke

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represented by any group or association who appears before us; it is not necessary that it be accurate to the last individual.

THE CHAIRMAN: The same question we asked the Manufacturers' Association this morning.

MRS. CLARKE: Well, I still cannot give you a figure because I really do not know one. We are a minority political party in this country and the exact number of people that we represent would be more than just the membership of our party because of the support that we do get from certain sections of the population.

COMMISSIONER McCUTCHEON: Could Mr. Dewhurst be a little more helpful?

MR. DEWHURST: Not very much in terms of the actual membership. We are a political party a little different from the Canadian Manufacturers' Association who have an economic organization. We represent a very substantial point of view ---

COMMISSIONER McCUTCHEON: You cannot give me a number so I will take it you cannot answer the question.

THE CHAIRMAN: What is the position, Mrs. Clarke's position and yours so that we may weigh the matter from that standpoint?

MR. DEWHURST: My position?

THE CHAIRMAN: Yes.

MR. DEWHURST: You mean my official position?

THE CHAIRMAN: Yes.



represented: any form of association and so on.

He said that it is not necessary that it be a matter.

He said that the fact of association is not a matter.

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4 MR. DEWHURST: I am national education  
5 director of the Communist Party and Mrs. Clarke is  
6 Metro Toronto secretary of the Party.

7 THE CHAIRMAN: And as educational  
8 director you are not able to give us the approximate  
9 number of your membership in Canada that you are educating?

10 MR. DEWHURST: That is true enough, yes.

11 COMMISSIONER FIRESTONE: Mrs. Clarke,  
12 can we turn to page 7 where you advocate:

13 "... a non-contributory comprehensive  
14 "national health plan with the Federal  
15 "Government bearing full responsibility  
16 "for the health of the people."

17 And you say further:

18 "... as a step in the right direction,  
19 "support a national health plan jointly  
20 "financed by the Federal and Provincial  
21 "Government and individual and family  
22 "premiums."

23 Do you have in mind in this step in  
24 the right direction a plan that would be provincially  
25 administered with financial contributions forthcoming  
26 from the Federal Government?

27 MRS. CLARKE: If necessary though our  
28 feeling is in order to have the really efficient plan  
29 in Canada it should be established centrally through  
30 the Federal Government with the co-operation of the  
provinces. There are today vast disparities from one  
part of Canada to another which we feel should be  
overcome but we also are very much of the opinion that





Clarke

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3 there must be some health plan and so it would be a  
4 step but we feel certainly not a big enough step.

5 COMMISSIONER FIRESTONE: But you try  
6 to understand the administrative arrangement and in that  
7 step in the right direction you are visualizing this  
8 administration be carried on by the provincial or federal  
9 level as a ---

10 MRS. CLARKE: I would think either,  
11 the difference is not so much whether it is administered  
12 federally or provincially but a question of the  
13 contributory or non-contributory basis of it and the  
14 second proposition is that it could include the  
15 contributory side.

16 COMMISSIONER FIRESTONE: What you  
17 appreciate if one wanted to implement the plan that  
18 would be nationally administered one would have certain  
19 difficulties given the present constitutional set-up  
20 and that is why my question was whether you would visualize  
21 the plan as a step in the right direction which is in  
22 the constitution of set-up as we have it now, is that  
23 your idea?

24 MRS. CLARKE: Yes, I think so except  
25 we have had, of course, the experience in Canada of  
26 having to change the constitution for the Unemployment  
27 Insurance Act which also was confronted with the same  
28 type of problem. I think it could be done for something  
29 like a national health plan. The constitution is not  
30 something that cannot be amended.

COMMISSIONER FIRESTONE: Thank you  
very much.





There must be some thing about it which I would like

to know and I am sure you will be able to tell me

something about it. But you say

to a certain extent, the whole thing is a hypothesis and in that

even in the most direct of your own reasoning this

and illustration be considered as the principle of Federal

level as a whole

very little. I would think at least

the difference is not so much in the matter it is in the

method of approach, which is a question of the

classification of material before the court. I am sure

you would agree that it is a question of the

method of approach.

There is a difference in the way

approach is the method of approach the plan that

would be a completely different one and would have certain

difficulties given the present constitutional group

and that is why my question was whether you would consider

the plan as a step in the right direction which is in

the constitution of the group as we have it now, is that

very little?

Yes, I think so except

we have a, of course, the existing in force of

having no doubt the constitution is the same

the same but I am sure you would agree with me that

group of members. I think it is the same in something

I like a national health group. I am sure it is not

some. The same must be understood

There is a difference in the way

very little.



Clarke

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THE CHAIRMAN: Thank you.

THE SECRETARY: The next submission is  
that of the Sudbury District Medical Society and it  
will be exhibit 289.

---EXHIBIT NO. 289: Submission of the  
Sudbury District Medical  
Society.

SUBMISSION OF  
THE SUDBURY MEDICAL SOCIETY

APPEARANCE: Dr. J.W. Sturtridge





Sturtridge

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DR. STURTRIDGE: In 1960 the Sudbury District Medical Society appointed a Committee with the terms of reference:

(1) to establish the present or future need for an additional School of Medicine in Ontario.

(2) to explore the hospital and professional facilities available in this region in the light of this need.

(3) to establish and maintain liaison with the Laurentian University of Sudbury.

The members of the Society feel that the contents of this Committee's report fall within the general terms of reference of the Royal Commission on Health Services and have instructed their Executive to submit this report for your consideration.

I will submit it only in brief summary and I will be pleased to answer any questions I am able to.

The report indicates that in the light of Canada's present and projected population increase and the attrition of doctor population by death and retirement, that we will require to graduate 1300-1400 doctors per year by 1975 in order to maintain the present doctor population ratio. Present medical schools are graduating only 850-900 per year and there is no evidence of probable immediate increase. The present addition loss by emigration has only been met by extensive doctor







Sturtridge

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immigration which has virtually ceased in Ontario as a result of policies adopted in July, 1960. It is felt that there must be a drastic increase in the number of Canadians enrolled in medicine and that this can probably only be met by an increased number of Medical Schools.

In 1960, 140 Sudbury Secondary School students entered University and 25 of these enrolled in Medicine. This is expected to be as high as 35% by 1965. The principal reason why prospective medical students do not enroll has been shown to be economic, and local availability of a medical school can be expected to increase the number that will enroll by at least 25%. Hence, the Sudbury area could be expected to provide approximately 35 to 40 medical students per year if a school were locally available.

Most medical schools in Canada have a hospital bed-to-student ratio of 20:1. This area has presently 950 available beds, exclusive of bassinettes. There are presently physical deficiencies such as lecture room, student facilities, out-patient clinics and intern residences but these could be included in planned building programs of local hospitals if a decision were made to have a school here ultimately.

There are now 71 specialists in the area, out of a total number of 130, who are certified by the Royal College of Physicians and Surgeons of Canada, of whom 20 are Fellows of the College. These specialists include:

5 Internists

6 Obstetricians and Gynaecologists





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3 Pathologists

3 Paediatricians

24 Surgeons

5 Radiologists

While these alone would not be adequate for a teaching staff, it is anticipated that a decision to establish a medical school at the Laurentian University of Sudbury would attract other staff of teaching caliber.

The Sudbury District Medical Society therefore respectfully suggest that a clear need for additional medical schools in Canada has been demonstrated and that the Sudbury area could provide the necessary population, hospital facilities and a nucleus of teaching staff for a medical school graduating 40 students per annum.

THE CHAIRMAN: Thank you, Dr. Sturtridge. Your basic proposition that there is a shortage, particularly a shortage for the future, is in line with other submissions, as you know.

DR. STURTRIDGE: Yes, sir.

THE CHAIRMAN: There is one sentence here I wonder if you could throw some light on. At the foot of page 1, top of page 2:

"The present additional loss by emigration has only been met by extensive doctor immigration which has virtually ceased in Ontario as a result of policies adopted in July, 1960."





1. The first point is that

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26. The twenty-sixth point is that

27. The twenty-seventh point is that

28. The twenty-eighth point is that



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This is something new, as far as I am concerned. What are you referring to here?

DR. STURTRIDGE: May I refer you to the brief? I would like to read a small portion of the body of the brief itself, sir. Last paragraph, page 4, continuing at the top of page 5.

"Assuming that Canadian schools will graduate 850 doctors in 1965, when our minimal basic requirements will be 1,100, we are left with a deficit of 250. But this calculation does not take into account loss by emigration - mainly to the U.S.A. - which currently is estimated at approximately 230 per annum from Canada (Medical Economics, C.M.A.J., vol. 78, 966, 1958). This consideration will leave us with a gross deficit by 1965 of 480 doctors p.a. in Canada. The high rate of physician immigration obtaining in recent years, and which for the period 1952-1956 amounted to almost 1/3 of all physicians licensed, obtained their licence, to practice in Canada during those years, and which in Ontario amounted to no less than 40% of new physicians licensed in 1959 (see Appendix #2), cannot reasonably be expected to continue. The recent adoption (July 1, 1960)





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of certification by the Education Council for Foreign Medical Graduates as a pre-requisite for admission to intern training in Ontario will drastically reduce the number of foreign-trained doctors accepted."

THE CHAIRMAN: What was the change?

The question has not been specifically put but we were under the impression that there was a reciprocal arrangement by which doctors from the United Kingdom, more or less automatically, were entitled to registration. Was there a change in 1960?

DR. STURTRIDGE: These regulations, sir, are contained in a letter in Appendix 4 over the signature of Dr. J.C.C. Dawson, Registrar-Treasurer of the Ontario College of Physicians and Surgeons.

I won't read the entire letter. This does not refer, primarily, to graduates from the United Kingdom, for example. It's foreign graduates from other countries, and, in essence, what these regulations require - and I would like to stress that we are in no sense criticizing the adoption of these regulations.

THE CHAIRMAN: You are saying it is going to cut off the flow?

DR. STURTRIDGE: I think that has been amply demonstrated in our own area. For three years, up to and including 1961, I was Chairman of the Intern Committee at Sudbury General Hospital. Up to 1960 we reviewed as many as 80 to 100 applications per year for internship from graduates of foreign medical schools who







Sturtridge

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wished to come to Canada, do their two years internship, and then write the Canadian Councils.

After July, 1960, when these regulations were adopted, which required each of these graduates to write a set of five examinations before he could apply to intern in Canada; since that time the supply of applicants has dropped precisely to zero.

COMMISSIONER McCUTCHEON: These would be 80 to 100 from countries other than the United Kingdom and Northern Ireland?

DR. STURTRIDGE: That is correct, sir.

COMMISSIONER McCUTCHEON: What proportion of the doctors who came into Canada in the last 10 years are from countries to which this regulation now applies?

DR. STURTRIDGE: The figure of 40% of those licensed in 1959 does include those from the United Kingdom. Therefore, I cannot break this down further. There are, however, large numbers that have come, particularly from Hungary and from Spain. We have had a very large number of Spanish applicants in the past.

THE CHAIRMAN: I suppose those figures could be obtained from the College of Physicians and Surgeons?

DR. STURTRIDGE: A further breakdown, I am sure, could be obtained, sir.

THE CHAIRMAN: They have not yet been before us so we will be looking for them at that stage.

COMMISSIONER BALTZAN: The internship



1947

Statistics

...to come to Canada, ... their two years' experience.  
...and ... writes the Canadian Commission.  
...After July, 1947, when these regulations

...were adopted, which required each of these graduates  
...to write a set of five examination papers before he could  
...apply to return to Canada; since that time the majority  
...of applicants has dropped gradually to zero.  
...The following is a summary of the situation.

...as to the total number of graduates from the United  
...Kingdom and Northern Ireland.  
...Dr. ... That is correct, sir.  
...The following is a summary of the situation.

...tion of the persons who came into Canada in the last  
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...now applies?

Dr. ... The figure of 400 or  
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...before us so we will be looking for them at that stage.  
...The following is a summary of the situation.



Sturtridge

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4 examinations you refer to; are they the ones that  
5 obtain in the U.S.A. or in Canada a parallel set of  
6 examinations?

7 DR. STURTRIDGE: This is an inter-  
8 national organization. They are the same examinations  
9 as required in the U.S.A.

10 THE CHAIRMAN: Dr. Sturtridge, as you  
11 will appreciate, the establishment of another medical  
12 school anywhere in Ontario is purely and wholly a  
13 provincial matter.

14 DR. STURTRIDGE: We understand that.

15 THE CHAIRMAN: This Commission becomes  
16 interested in the subject because of its concern of the  
17 supply of qualified personnel for health services in  
18 Canada so that the subject is relevant to the inquiry  
19 in that regard.

20 The Ontario Medical Association also  
21 supported this. Their view, as expressed, was there  
22 should be two additional medical schools in Ontario.  
23 They did not attempt to spell out where those schools  
24 should be established but they did suggest that at  
25 least one should not be in the Toronto area.

26 Just what is your view, so far as this  
27 Commission is concerned, of anything that could be done  
28 by this Commission that would further the situation inso-  
29 far as Sudbury is concerned in the light of what is the  
30 actual situation, that it is a provincial Government  
matter, a Provincial Government decision, as to where  
the college should go? The Provincial Government put  
up the money.







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DR. STURTRIDGE: I think I should make one thing clear, sir; that when we initially decided to present this which had been a Committee report of our District Society previously to your Commission, we felt that the first section of the brief, dealing with what we feel to be a potential danger of the shortage of doctors, was the, perhaps, more important in terms of reference by this Commission.

At that time, of course, we did not know that Dr. Thomson: of Alberta and the Canadian Medical Association would be presenting essentially a similar and perhaps more extensive brief. Nevertheless, we felt this is a matter of sufficient importance - it still should be presented.

THE CHAIRMAN: This is very proper. You should have done so.

DR. STURTRIDGE: We recognize that this Commission cannot properly say you feel there should be a medical school in Sudbury. This would be beyond your scope.

Nevertheless, we felt that we would like to bring into the public eye, in some manner, the fact that there is the possibility of having such a school in that area.

COMMISSIONER FIRESTONE: Following up the line of questioning that the Chairman has just developed, I am just wondering whether you would feel that in view of the serious shortage that might be developed, as far as medical personnel in Canada is concerned, the Federal Government might make a financial



DR. STURTEVANT: I think I should make

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At that time, of course, we did not

know that Mr. Thomson of Alberta and the Canadian Medical Association would be presenting essentially a similar and perhaps more extensive brief. Nevertheless, we felt this is a matter of sufficient importance - it still should be presented.

THE CHAIRMAN: This is very proper.

You should have done so.

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this Commission cannot properly say you feel there should be a medical school in Calgary. This would be beyond your scope.

Nevertheless, we felt that we would like to bring into the public eye, in some manner, the fact that there is the possibility of having such a school in that area.

COMMISSIONER: Following up

the line of questioning that the Chairman has just developed, I am just wondering whether you would feel that in view of the serious shortage that might be developed, as far as medical personnel in Canada is concerned, the Federal Government might have a financial



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contribution to the Provincial Government to assist those provincial governments in the establishment of new medical schools covering either capital cost or operating cost or both?

DR. STURTRIDGE: I am afraid, sir, I would not feel qualified to answer whether the Federal Government should contribute directly to something in the realm of education. I think that this Commission of the Federal Government could properly stress, if you agree with these findings, the need for further medical schools in general.

COMMISSIONER FIRESTONE: Have you worked out a budget of what would be involved in establishing a medical school in Sudbury? The operating cost? The capital cost?

DR. STURTRIDGE: No, sir. I would preface my answer to that by pointing out this submission is from the doctors of the Sudbury area and I do not represent or speak for the Laurentian University of Sudbury.

This brief has been presented to the Laurentian University and is under consideration by the Board of Governors. They have not publicly indicated they would be in favour of this or not and such a decision would be necessary before we can go on to budgetary considerations.





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MR. STURGEON: No, sir. I would

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 Association of Universities and is under consideration by the  
 Board of Governors. They have not publicly indicated  
 any action as far as this or not and such a  
 decision would be necessary before we can go on to  
 further consideration.



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4 COMMISSIONER FIRESTONE: As I under-  
5 stand it, sir, looking at your page 16 you would  
6 visualize such a university to be developed in two  
7 stages, starting out in the first stage with pre-clinical  
8 medical courses and the second stage of a complete  
9 medical school; is that correct, sir?

10 DR. STURTRIDGE: On this matter, as  
11 you are well aware there are two methods by which a  
12 school can be established. You have outlined one.  
13 The other is to establish the full six-year course year  
14 by year. On this particular point the members of the  
15 society and the members of the Committee that drew up  
16 the brief were not in complete agreement. There were  
17 some variety. If you wish my personal views, and it  
18 is a personal view, I feel if the possibility of having  
19 a medical school at the University of Sudbury should  
20 come about they would be wiser to go ahead with the  
21 entire course year by year.

22 COMMISSIONER FIRESTONE: Thank you  
23 very much.

24 THE CHAIRMAN: Dr. Baltzan?

25 COMMISSIONER BALTZAN: I have one  
26 question: In your conversation over the university, are  
27 they willing to undertake the establishment and develop-  
28 ment of a medical school according to your proposition?

29 DR. STURTRIDGE: Are they willing?

30 COMMISSIONER BALTZAN: Yes.

DR. STURTRIDGE: They haven't committed  
themselves for against. It is still under their  
consideration.



stand it, and, looking at your face, it would

visualize as a university to be developed in the

state, starting out in the first stage with pre-clinical

medical courses and the second stage of a complete

medical school; is that correct, sir?

DR. STEPHENSON: In this pattern, yes.

You see well aware there are two methods by which a

school can be established. You have outlined one.

The other is to establish the full eleven courses year

by year. On this particular point the members of the

society and the members of the Committee that were up

the chief were not in complete agreement. There were

some variety. If you wish my personal views, and if

as a personal view, I feel if the possibility of having

a medical school at the University of Indiana should

come about that would be better to go ahead with the

entire course year by year.

COMMISSIONER: I think you

very much.

DR. STEPHENSON: Yes, sir.

COMMISSIONER: I have

question: In your conversation over the university, are

you willing to undertake the establishment and develop-

ment of a medical school according to your proposition?

DR. STEPHENSON: The only difficulty

is the financial matter.

DR. STEPHENSON: They haven't committed

themselves to it yet. It is still under their

consideration.



Sturtridge

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4 COMMISSIONER BALTZAN: It would be  
one of the things to come before you proceed?

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6 DR. STURTRIDGE: I realize this in  
7 many ways sounds premature, but I think I should say one  
8 of the reasons we have started this thing in the first  
9 place was because the university was beginning to  
10 consider their overall complete plan and we wished to  
11 have some blueprints for the future laid down, if at  
12 all possible, before various things had gone too far  
in one direction.

13 COMMISSIONER BALTZAN: Universities  
14 are generally very reluctant because the Faculty of  
15 Medicine and the allied faculties are a very heavy  
burden.

16 COMMISSIONER McCUTCHEON: It is not  
17 one of the paying departments?

18 COMMISSIONER BALTZAN: : No. Thank  
19 you.

20 THE CHAIRMAN: Miss Girard?

21 COMMISSIONER GIRARD: I would like just  
22 to ask one thing: Has the School of Nursing begun  
functioning yet at the university?

23 DR. STURTRIDGE: Not at the university.  
24 This is another question that is under consideration.  
25 As I am sure you are aware there are two schools of  
26 nursing at Sudbury, at the General Hospital and the  
27 St. Joseph's Hospital. There is a proposed nursing  
28 school at the Memorial Hospital and there is a move  
29 by a considerable number of persons in the area to have  
30 this become a university nursing school, in some manner





JOHN: I would like to see...

one of the things to come before we proceed.

JOHN: I realize this in...

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of the reasons we have started this thing in the first

place was because the university was beginning to

consider their overall corporate plan and we wanted to

have some discipline for the future laid down, if at

all possible, before various things had gone too far

in one direction.

CONSTITUTIONAL POLICY: The university

are generally very reluctant because the faculty of

medicine and the allied sciences are a very heavy

CONSTITUTIONAL POLICY: It is not

one of the paying departments?

JOHN: I would like to see...

CONSTITUTIONAL POLICY: I would like to see...

to ask one thing: Has the school of medicine been

there since you started?

JOHN: Yes, at the university.

This is another question that is under consideration.

As I said, you are aware there are two schools of

medicine at Sydney, at the General Hospital and the

St. Joseph's Hospital. There is a proposed merger

school at the General Hospital and there is a new

we are considering a number of persons in the area to have

this become a university medical school, in some manner



Sturtridge

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3 incorporating one or more of these schools.

4 COMMISSIONER GIRARD: Nothing has  
5 been definitely done yet in that regard?

6 DR. STURTRIDGE: No.

7 COMMISSIONER GIRARD: Thank you.

8 THE CHAIRMAN: What other departments  
9 are there from which medicine might logically be an  
10 outgrowth?

11 DR. STURTRIDGE: Departments?

12 THE CHAIRMAN: Of the university.

13 DR. STURTRIDGE: We feel that there  
14 is a meeting of minds in the arts and sciences, between  
15 the arts on the one hand and medicine on the other in  
16 the fields of physiology and biochemistry and certain  
arts and science areas where the two overlap.

17 THE CHAIRMAN: How many students are  
18 there enrolled at the university, that is winter course  
19 enrolment, in the regular course?

20 DR. STURTRIDGE: I can't answer that,  
21 sir. I think perhaps Dr. Lynch who is present, and who  
22 is, incidentally, chairman of a committee who drew up  
this brief, might know that.

23 DR. LYNCH: I think it is just about  
24 400. The university is only three years old.

25 DR. STURTRIDGE: That is correct.

26 THE CHAIRMAN: Did you make any survey  
27 of potential recruitment, potential medical students in  
28 terms of high school population and that kind of thing?

29 DR. STURTRIDGE: Yes sir. If I might  
30 refer you to appendix 5, page 3, these figures were





Sturtridge

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provided from studies done by Reverend Father Ferland, Dean of the Faculty of Arts and Sciences, University of Sudbury. The figures begin in 1959 and are projected to 1965 dealing with North Eastern Ontario as a whole, and the area within a 50 mile radius of Sudbury and the area within a 25 mile radius of Sudbury. There is the number of Grade XIII students in the various faculties in which they are now enrolled, and the number they anticipate will be enrolling in various faculties according to surveys they have done. For example, in 1959 within a 50 mile radius of Sudbury 455 enrolled in Grade XIII. There were 25 in the first year medicine, 54 in arts, 12 in engineering, 8 in law and 8 in commerce. Those are the figures for each year.

THE CHAIRMAN: What is there at Sault Ste. Marie? How far away is that?

DR. STURTRIDGE: Sault Ste. Marie is about 180 miles.

THE CHAIRMAN: What is there? Is there anything there?

DR. STURTRIDGE: In terms of what?

THE CHAIRMAN: In terms of potential college.

DR. STURTRIDGE: The population at Sault Ste Marie is much smaller. Their doctor population, I believe, is about 45 or 50 doctors in the area. The hospital is very much smaller, and they don't have any university or college facilities at the present time.

THE CHAIRMAN: Have you anything to add, Dr. Sturtridge?



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DR. STURTRIDGE: No sir, I would like to thank you gentlemen for your interest, and Miss Girard.

THE CHAIRMAN: This whole question of whether there is an adequate number of medical schools in Ontario is going to be one that has to be dealt with very seriously, and the representation, as I say, to location cannot fall within the scope of this Commission to recommend, but it is not difficult to say somebody is going to have to accept the idea one or two additional medical schools are going to have to be build in Ontario.

DR. STURTRIDGE: I may say, sir, this brief is not being presented only to this Commission, but has been sent elsewhere.

THE CHAIRMAN: Thank you again, Dr. Sturtridge.

THE SECRETARY: The next brief is that of Dr. Matthew J. Lynch, a private brief, and it will be known as exhibit 290.

---EXHIBIT NO. 290: Submission of Dr. Matthew L. Lynch.



like to think you considered for your interest, and this  
 is all.

THE CHAIRMAN: This whole question of  
 whether there is an adequate number of medical schools  
 in Ontario is going to be one that has to be dealt with  
 very seriously, and the representation, as I say, to  
 location cannot fall within the scope of this Commission  
 to recommend, but it is not difficult to say somebody

is going to have to accept the idea one or two additional  
 medical schools are going to have to be built in Ontario.  
 Dr. STURTEVANT: I say, sir, this  
 point is not being presented only to this Commission,

but has been sent elsewhere.  
 THE CHAIRMAN: Thank you again, Dr.

THE SECRETARY: The next point is that  
 of Dr. Latham, I think, a private member, and it will  
 be known as Exhibit 100.

---EXHIBIT 100---  
 Submission of Dr. Latham  
 11/1/51.



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SUBMISSION OF  
DR. MATTHEW J. LYNCH

APPEARANCE: Dr. Matthew J. Lynch

THE CHAIRMAN: Dr. Lynch, we are  
pleased to see you again.

DR. LYNCH: Thank you, Mr. Chairman.  
I would like your direction as how to proceed, sir.  
Do you wish me to read the conclusions?

THE CHAIRMAN: If you will, and summarize  
and so forth. This is a long document, which I  
appreciate you have not intended to read, because it  
contains such a great volume of factual information.  
It is exceedingly valuable. Your comments and  
recommendations we would be pleased to have.

DR. LYNCH: My purpose in getting  
this brief together was to assemble some body of facts  
and experiences of schemes in other countries. I  
confined myself to those in Germany, Austria, Russia ,  
New Zealand, Australia and Sweden, because I had been  
studying those quite a lot and I felt they represented  
the different aspects of the application of the national  
health scheme in medicine and we might benefit from their  
experience.

Through a study of these schemes  
certain conclusions became obvious even on a short  
study:

(1) None of these schemes lend support to  
the claim that availability of the means to good health





Mr. Matthew J. Lynch

Secretary

THE CHAIRMAN: Mr. Lynch, we are

pleased to see you again.

I would like your director as how to proceed, sir.

Do you wish me to read the conclusions?

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and so forth. This is a long document, which I

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to this report, whether we to assemble some body of facts

and experiences of scholars in other countries.

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New Zealand, Australia and Sweden, because I had been

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health scheme in medicine and we might benefit from their

perhaps a study of these schemes

and in conclusion factors obvious even on a short

study:

One of these schemes found support in

the fact that realization of the scheme would



Lynch

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4 will reduce the incidence of sickness. Rather does  
5 experience suggest that there is no limit to the degree  
6 of care necessary to arrive at the utopian "state of  
7 complete physical, mental and social well-being.", as  
8 defined by World Health Organization.

9 (2) The statistical experience of the  
10 prototype scheme, that is the German scheme, which  
11 has now been in operation for 78 years, strongly suggests  
12 that, so far from improving the health of a nation, such  
13 schemes actually work to the detriment of national  
14 health. There is ever reason to believe that the health,  
15 happiness and wealth of the German and Austrian people  
16 today would have been immeasurably greater had Bismarck's  
17 imagination never been fertilized to conceive Social  
18 Sickness Insurance. It is not improbably that it is  
19 because of these facts the proponents of State Medicine  
20 never refer to the experiences of Germany any more -  
21 experiences which, I respectfully submit, are the most  
22 valid of all since they are of longest duration.

23 (3) The proponents, you will note, Mr.  
24 Chairman, I refer to the proponents, and if there is  
25 time I would like possibly to expand this subsequently  
26 at the Commission's pleasure -- the proponents of  
27 Socialized Medicine claim that theirs is the only milieu  
28 under which Preventive Medical Care can be effectively  
29 practiced. Experience proves the contrary. All  
30 available evidence shows that preventive medical  
achievements in such countries as Germany, Austria and  
Russia fall far behind those attained on this continent in  
an atmosphere innocent of compulsion and central







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4 bureaucratic planning. It is premature to assess  
5 results in such countries as New Zealand and Sweden,  
6 which have had compulsory schemes for 20 and 7 years,  
7 respectively. However, of these latter countries it  
8 can be unequivocally said that there is no evidence  
9 of improved health since the inception of national  
10 plans. Indeed, statistics of hospitalization and sickness  
11 certification in these two countries would seem to  
12 indicate a loss of "complete physical, mental and  
13 social well-being" since the inception of compulsory  
14 schemes.

15 (4) Those who advocate Socialized Medicine  
16 claim that such a system would provide an equitable  
17 distribution of physicians. Experience tends to prove  
18 the opposite. Even the Minister of Health of the Russian  
19 Soviet Federated Socialist Republic, which encompasses  
20 75% of the land mass and 56.2% of the population of the  
21 U.S.S.R., has admitted as late as 1960 to a gross  
22 inequality of distribution of physicians - and this in  
23 a country with the largest per capita number of doctors  
24 and absolute central control of these doctors. In  
25 Sweden, after 274 years of a State-operated medical  
26 officer system, no less than 17% of these posts are  
27 vacant; while the average medical officer cares for  
28 4,000 persons, many have to look after populations up  
29 to 15,000; yet, in Stockholm there is 1 doctor for  
30 each 625 persons. I would like to add here in  
parenthesis that I have just received recent statistics  
from Sweden and the situation has got worse. Now there  
are 450 in Stockholm; 640 in Goteborg and 700 doctors







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4 in Malmo, and the ratio in the rest of the country-  
5 averages out to 1 per 4500. That is the latest  
6 statistical aspect in Sweden. In Austria, over 85%  
7 of specialists are in Vienna.

8 (5) Proponents of socialized medicine  
9 argue that their formulas will make better care  
10 available to all at less cost. There is absolutely  
11 no evidence to support this. Under all national systems  
12 costs have skyrocketed and it is always the poorest  
13 elements in society that are most grievously affected  
14 by the resultant inflation of costs. Rising prices of  
15 staples necessitate additional and increased 'social'  
16 measures to alleviate the plight of the less than well  
17 off. This constitutes the vicious cycle in Social  
18 'Security', and it is not inconceivable that it is one  
19 of the main reasons why those who wish us to have a  
20 controlled and planned society are so eager to promote  
21 socialized medicine. They know that once they have  
22 obtained this measure much of the rest will follow of  
23 necessity. The experiences of Sweden should be a  
24 lesson to any young, vigorous and sane nation.

25 (6) The advocates of Socialized Medicine  
26 argue that it will relieve the doctor of economic  
27 worries and permit him to devote all his energies to  
28 his profession. Again, experience shows this to be  
29 remote from the truth. Professional unrest,  
30 dissatisfaction, threatened and actual strikes have been  
the rule in all national, Government or bureaucratically  
controlled medical schemes. Actual strikes have been  
a feature of all. In Russia, where strikes are prevented



in which, and the fact that the report  
averaged out to a very low level of  
statistical report in the field. In addition, even the  
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agree that their formula will not be better  
available to all the field. There is a possibility

in evidence to suggest that, under all national systems

costs have skyrocketed and it is always the poorest

the rate in society that are most grievously affected  
by the resulting inflation of costs. The rising prices of  
needed necessities additional and increased in the

measures to alleviate the plight of the poor have

been. This constitutes the vicious cycle in the field

of the field, and it is not inconceivable that it is

of the main reasons why those who wish to have a  
controlled and planned society are so often so worried

concerned with the field. They know that if they have

achieved this measure, even if it is not followed by

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reason to see that, however and how it is

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Lynch

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4 by legislation, protest has taken more subtle forms  
5 such as disregard of government orders and a profession  
6 that is 80% female.

7 (7) Some proponents of Socialized Medicine  
8 have been rash enough to suggest that their milieu  
9 would permit better and more fruitful planning and  
10 co-ordination of research personnel, equipment, facilities  
11 and projects. Experience shows how sadly misguided this  
12 concept is. German and Austrian medical research -  
13 probably the greatest concentration of productive  
14 research the world has ever seen - was emasculated within  
15 the lifetime of one generation (actually within 2  
16 decades) by social sickness insurance. Russia has a  
17 most promising school of research and had contributed  
18 much before 1918: since that time her contributions  
19 have been virtually nil. Dr. Robb tells us that New  
20 Zealand univerisity medical schools have been starved  
21 of research personnel by its scheme - that anyone with  
22 ability emigrates. The danger signs are already clear  
23 in Great Britain after only 13-1/2 years.

24 (8) To date no advocate of Socialized  
25 Medicine has been rash enough to claim for it an  
26 innocence of malingering, and this is understandable.  
27 German, Austrian and Russian experiences alone suffice  
28 to discourage any such idea.  
29  
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In addition, present is a third more subtle form.

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Lynch 10561

WHY SOCIALIZED MEDICINE FAILS:

If one attempts to seek the reasons why these unfortunate results should ensue from what might be construed as an altruistic motive to make good medical care available to all, one must face the following conclusions: -

(a) There is little if any parallel between Public Health and Personal Health Care. The former concerns itself with the provision of such things as adequate housing, hygienic food and water supplies, sewage disposal, prevention of epidemics, etc., i.e. it is concerned with THINGS. Personal health care, on the other hand, is concerned with the individual, and it has all the facets and overtones, all the qualities and peculiarities that make the person an individual. Personal health care cannot be supplied as one purveys gas, electricity, water or food.

(b) In the field of health care, once personal responsibility is removed, collective selfishness replaces the restraints of the individual conscience. Individual morality declines as public responsibility increases. This results in greatly increased demands on existing manpower and facilities: the doctor is more likely to miss the serious illness because of the many frivolous claims on his time. But, worse than this, the authorities are forced to look to the doctor to replace patient responsibility. The physician is appointed unwillingly as guardian of the treasury to ration the scheme's benefits. This poses an insoluble conflict for the doctor who, on the one hand must trust all his patients if he is



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Lynch 10562

to act his true role of professional confidant and advisor, but on the other hand, and at the same time, must mistrust and suspect every patient if he is to protect the solvency of the scheme. In a word, the basic doctor-patient relationship, which is a sine-qua-non of good medical care, is destroyed by all schemes that remove responsibility from the patient.

RIGID PLANNING INCOMPATIBLE WITH MEDICAL PROGRESS:

Long-term planning, such as is necessary for any national scheme of medical care, commits medicine to a rigidity within which it must inevitably wither. The basis of progress is adaptability to changing conditions and environment. To keep pace with modern advances medicine must remain free and flexible. Only such a climate will continue to attract the enquiring minds upon whose contributions the future of Canadian medicine will depend. These minds cannot be planned, but all experience shows that such untrammelled intellects are repelled or stifled by bureaucratic planning.

The progress of medicine, like the maintenance of health, depends on nothing more nor less than the continued successful adaptation to a changing environment. I would respectfully recommend this definition to the Commission. With equal respect, I would suggest that the realization of good medical care under a socialized system is as impossible as is that of the World Health Organization's concept of health. On analysis, I am forced to conclude that "a state of complete physical, mental and social well-being" is to be achieved only by hibernation or death!



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stitutional, mental and social well-being" is to be achieved  
only by liberation of the mind.



Lynch 10563

It is paradoxical that - at the very time when most countries who have embarked on socialized medical schemes are questioning the wisdom and results of these plans - there would appear to be such meretricious party political interest in them Canada. But, perhaps, it is because time is fast running out that this interest is being spuriously generated. In this connection, Her Majesty's Government in Ottawa is to be commended for its wisdom in submitting this whole matter to the factual and impartial inquiry by a Royal Commission. It is to be hoped that other National political parties will respect the deliberations of this Commission and that they will refrain from converting the health care of Canadians into a political football!

All of which is respectfully submitted.

THE CHAIRMAN: Thank you, Dr. Lynch. There is one item that you said you were going to go back to make a reference to. Something about some definition of the proponents of socialized medicine when you started number 3.

DR. LYNCH: If the Commission would like me to do so, I would be glad to do it.

THE CHAIRMAN: To do what?

DR. LYNCH: To outline the international background of this movement, sir.

THE CHAIRMAN: I don't know that we want that.

DR. LYNCH: I submit to your judgment.

THE CHAIRMAN: It started with Bismarck 78 years ago.



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it is paradoxical that - at the very

time when these countries who have embarked on economic

policy have been questioning the wisdom and necessity

of these plans - there would appear to be some reason

why the policy should be continued in these countries.

It is because there is something out there that is

being sought after, in this connection, and

the Government in Ottawa is to be commended for

its vision in addition to this whole matter of the future

and financial policy by a Royal Commission. It is to

be hoped that other national political parties will

support the deliberations of this Commission and that they

will be able to bring forward the best case of Canadian

into a political formula.

All of which is respectfully submitted.

There is one item that you said you were going to go back

to take a look at. Something about some of the

of the proposals of economic and financial policy.

Thank you.

Very truly yours,

John D. Macdonald

John D. Macdonald

John D. Macdonald

John D. Macdonald

John D. Macdonald



Lynch 10564

DR. LYNCH: I am not referring to that, Your Honour, I am referring to the super-government situation which is arising today through the influence of the international bodies ---

THE CHAIRMAN: These no doubt would make a very interesting discourse, but I think you would be the first to admit that this Commission has little in its terms of reference that would permit it to look into the status of I.L.O. and the rest of these institutions.

COMMISSIONER FIRESTONE: Dr. Lynch, do you approve of the Canadian Hospital Insurance Plan as it is presently in existence in Canada?

DR. LYNCH: No, sir.

COMMISSIONER FIRESTONE: Can you give us some of your reasons for your objections?

DR. LYNCH: Well, Mr. Chairman, I was responsible some four years ago, five years ago now, for getting a group together in Sudbury that wrote a brief to Premier Frost on this before it was brought in. It is my feeling, sir, I am speaking personally, that undoubtedly the scheme has some good. There is hardly anything that is all bad, but it is my personal feeling, sir, that a better arrangement could have been arrived at had the Government assumed a responsibility merely for that group who couldn't afford.

The people of Ontario had already demonstrated their willingness and ability to support private hospital insurance, and I would submit, sir, that the same result, nay, a much better result, could have







Lynch 10565

been obtained by the Government merely looking after that small group, maybe 10% of the population, and if that had been done, we would not see the spiralling costs we see today.

In the present scheme there is no incentive to economy in the hospitals, absolutely none whatsoever. The profit and loss system has been swept aside, and I submit that even in health care, which costs money, you cannot afford to ignore profit and loss, and immediately a thing becomes public, we have seen this in the hospitals, there is a feeling that everybody employed in a hospital must get what they call a going rate of pay.

I am not advocating that people should be kept at unrealistically low levels of payment, but I do submit that our society has probably produced the greatest material benefits for mankind, and it has done so by a patchwork, and part of that patchwork in the realm of hospitals is that people who are part qualified would accept jobs at lower remuneration. Today, when practically the whole hospital system is unionized, hospitals are forced to pay a phenomenal amount. 70% of the budget, which this year is over \$2,000,000.00, is wages alone. Pretty soon this will conflict with the essential needs of the hospital with regard to facilities and the adequate remuneration of the more highly-qualified people. Already that is apparent. The Hospital Services Commission has refused to honour the recommended salaries for our highest grade of laboratory technicians.

I think I could go on about this, sir,



Lunch 10:00

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Lynch 10566

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4 but I don't wish to make a speech about it, but I see  
5 nothing good in this, sir, and I would prognosticate that  
6 this will be the death of the Canadian hospital system  
7 eventually, because we can see it, sir, the public purse  
8 is going to have to be controlled, and this control will  
9 be the same as every place else, by controlling services,  
10 not by controlling costs locally, but by limiting  
11 services, and we can see already in the projections of the  
12 Ontario Hospital Services Commission. There is no increase  
13 in beds planned right up till 1965. There is absolutely  
14 no increase per head of population. In Toronto I believe  
15 we are 8,000 beds short. All they do is establish a  
16 committee, and this is what happens under a Government.  
17 If you leave it to the people they will provide for a need  
18 as they see it.

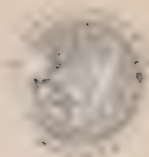
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20 COMMISSIONER FIRESTONE: Do you have  
21 any specific instances of wasteful use of hospital resources  
22 now that the Hospital Insurance Plan is in operation in  
23 the Province of Ontario?

24 DR. LYNCH: This is a touchy question,  
25 sir, but I am not going to dodge it. Yes, there is.  
26 Patients tend to stay a little bit longer, and they put  
27 pressure on their doctors to stay. I think the Ontario  
28 Hospital Services Commission is aware of this. They can  
29 do nothing about it, neither can the individual doctor.

30 COMMISSIONER FIRESTONE: Why?

DR. LYNCH: Sir, if I may make an  
analogy, and I am not being facetious here, sir. If you  
give a man a key to a liquor store, can you blame him for  
being an alcoholic?





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COMMISSIONER THIRTEEN: Do you have

any specific instances of wasteful use of hospital resources  
now that the Hospital Insurance Plan is in operation in  
the Province of Ontario?

MR. MASON: There is a lot of waste, sir, but I am not going to do the job, I am not  
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Hospital Services Commission is aware of this. They are  
do nothing about it, neither can the individual doctor.

COMMISSIONER FOURTEEN: Why?

MR. MASON: Well, if I have a man  
analysis, and I am not being serious here, sir. If you  
give me a case to a hospital, can you blame me for  
being an alcoholic?



Lynch 10567

COMMISSIONER FIRESTONE: I wonder if we can concentrate on the health situation and the physician. I take it that this particular patient goes to his doctor and he acts on his doctor's advice, and presumably there are procedures for hospitals that control stay, etcetera. Why could that not work efficiently in cooperation between the physician and the hospital administrator?

DR. LYNCH: It does work efficiently, sir ----

COMMISSIONER FIRESTONE: Well, if it works efficiently --

THE CHAIRMAN: He was going to continue.

DR. LYNCH: So efficiently, sir, that since this scheme came in I would say without any word of a lie that our extracurricular duties in the line of committees have doubled. We have increased the number of committees. I recently added up I have nine evenings out of every month gone on various committees.

The doctors are trying to do their best, but when you have a patient, and say she has come in and she has had her baby for example, and the doctor feels that she is ready to go home on the seventh day. He says: "Mrs. Smith, I think you can go home today or tomorrow", and she says: "Well now, Dr. Jones, I would like to stay just another day, because my husband will be on a different shift. He will be able to help me". Or: "My cousin is coming up from North Bay, and she will be able to help me". What is the doctor to do, sir?





Lynch

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Before, when she had Blue Cross, she realized beforehand that if she stayed an extra day it was going to cost more. Now she feels, and the Government tells her and all the politicians tell her, that she has a right to it. How can the doctor exercise his proper duty? He can be severe with the patient and say: "You have got to go home" but do you think she is going to like him for that?

COMMISSIONER FIRESTONE: Now, Dr. Lynch, can you not say this is a matter for the hospital administration to decide, that there is a large waiting list of patients and it is really not within your discretion; that the decision is really one of hospital administration? Would that not work on that basis?

DR. LYNCH: We tried that to an extent. For instance, we have an Admission and Discharge Committee and the Chief-of-Staff and at least one other doctor goes around quite frequently and makes the rounds of all these patients. It is extremely difficult when it comes down to personal relationships.

COMMISSIONER FIRESTONE: You said there were some good features in that program as it is in operation now?

COMMISSIONER McCUTCHEON: Before we get off the wasteful features can I ask one question? Would you say there is a tendency to use the diagnostic facilities, the lab facilities, blood testing and x-ray and so on facilities, to a greater extent than heretofore?

DR. LYNCH: Yes, there is. On the







Lynch

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average, our annual reports show that in the three years' operation the utilization by the number of tests has gone up 13%, 13 decimal-something percent each year. This is on a fixed-bed state.

COMMISSIONER McCUTCHEON: 13% each year?

DR. LYNCH: Yes, sir, that is on something that is already quite high. For instance, on half-a-million units of laboratory work.

COMMISSIONER McCUTCHEON: In other words, I am in hospital quite legitimately, let us say, and I say, "Well, I am here; I might as well have this procedure done or that procedure done"; is that what is happening?

DR. LYNCH: No, sir, that is not happening to my knowledge. I am not saying that is not happening, period, but as far as I know that is not happening or to a very slight degree. What is happening, is replacement of the individual conscience from the collective conscience and that is a psychological process that affects doctors as well as patients.

Perhaps I might give you an example as I experienced it myself: before, we did less work and I got less pay. Believe me, sir, I would happily go back to less pay to be able to practise medicine better because in the old days, before this scheme came in, a doctor would come to me and say, "I have a patient in 600 with such-and-such a problem" and I would frequently be able to go upstairs with that doctor and we would discuss the case and we would say, "Do you think we



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everyday, our annual report shows that in the last  
 years' operation the utilization of the number of tests  
 has gone up 13%, 14 tests are being performed each year.  
 This is on a third-bed state  
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Dr. LYNCH: Yes, sir, that is on  
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 100 with a disease such as 'leukemia' and I would like to  
 be able to get a certain amount of money and we would  
 discuss the case and we would say, "We can think of



Lynch

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should do so-and-so?" and we would narrow it down into a likelihood.

Then, I would say, "You might get the best results by doing this and this". Now, we are so inundated with work, there is no time for discriminatory work and the result is we are presented with a sheet, a battery of tests.

A patient comes in with something wrong with her liver so straight away she has a battery of liver tests. This does not happen with the whole profession; maybe only 25%, but this is the cause of tremendous increases and I would venture to say that if we had a national health service on a free-for-all basis, this would just go through the roof.

COMMISSIONER FIRESTONE: Is the implication of what you are saying that this 25% of doctors are not doing what is considered adequate professional methods?

DR. LYNCH: No, not at all.

COMMISSIONER FIRESTONE: What are you implying by that observation?

DR. LYNCH: These men were trained to work and to work within their field of medicine on a direct doctor-patient relationship. Now, a third party has come between them and removed responsibility from the patient. A lot of these patients ask for this themselves.

COMMISSIONER McCUTCHEON: That is what I said to you before and you questioned that; at least that is what I took it you said.





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a little while.

Now, I would say, "You might get the

best results by doing this and that". Now, we are  
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wrong with her liver so that she has a battery  
of liver tests. This does not happen with the whole  
of the body; maybe only 10%, but this is the cause of  
the trouble in the liver and I would venture to say that  
if we had a national health service or a free hospital  
system, this would just go through the roof.

Then of course you are saying that this is of course  
one not doing what is considered adequate professional  
service.

Well, I think it is a little

more serious than that; what are you

implying by that statement?

Well, I think it is a little

work and it is a little bit of work and it is a

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DR. LYNCH: I interpreted what you said as doing extra medical things. For instance, if a person came in to have their piles fixed, at the same time they might have a few moles off or something like this.

COMMISSIONER McCUTCHEON: No, I did not mean that. I meant that I was there so I might as well have my blood tested at the same time.

DR. LYNCH: Patients are putting pressure on the doctor for these tests.

COMMISSIONER FIRESTONE: But I take it the doctor, in prescribing a test, would use his professional judgment and would only prescribe things which he considered were required in accordance with his medical judgment?

DR. LYNCH: The vast majority of doctors do that but you must realize the doctors themselves are under tremendous pressure.

COMMISSIONER FIRESTONE: Even if a doctor is under pressure is this an excuse for him not to use his medical judgment?

DR. LYNCH: No, sir, if the normal economics obtain but if some scheme removes the normal forces of regulation can he be entirely blameworthy?

COMMISSIONER BALTZAN: If a patient asks you to have his Rh Factor determined, do you comply or refuse?

DR. LYNCH: If he asks me personally? This does not happen to me. If it is a case, most cases come to me from other doctors and if he is a married man



DR. LYNCH: I interpreted what you

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DR. LYNCH: I don't

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to use his medical judgment.

DR. LYNCH: No, not if the patient

... doctor's office but it is a very common thing and hospital  
... of hospital and it is an entirely different thing  
... it is a patient

... you to have his ... doctor's office, or you would

DR. LYNCH: It is a very common thing

... not a doctor's office. It is a case, most cases  
... it is a patient's office and it is a patient's office



Lynch

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and there is reason to suspect that he has a child with erythroblastosis, then we would do it.

COMMISSIONER FIRESTONE: You are using your medical judgment as to whether you will take it or not?

DR. LYNCH: But I do not have the chance to do it any more.

COMMISSIONER FIRESTONE: Who took the chance away from you?

DR. LYNCH: The volume of work.

COMMISSIONER FIRESTONE: In other words, you are under such pressure that you cannot use your own good medical judgment?

DR. LYNCH: Yes, we are under that pressure that we have not got time to discuss in detail the cases that the doctors are concerned with. It takes some time. A doctor comes in to you and you have to go to a floor to look at the case history, to examine the patient with him and to discuss this; it is at least 20 minutes.

COMMISSIONER FIRESTONE: Well, I appreciate that, that you should be under pressure, but even if you are under pressure, you are still using your best medical judgment in prescribing what tests are required?

DR. LYNCH: We try to.

COMMISSIONER FIRESTONE: Thank you very much. If I may go back to something you said a little earlier that there were some good features in the program as well: would you elaborate on some of those?





and there is reason to suppose that he has a child with  
some abnormality, that he would not let  
anybody know of his child, let alone using

your medical judgment as to whether you will take it  
or not?

Dr. L. W. H. H. Yes, I do not know the  
chance to do it any more.

the chance may be small  
the volume of work.

you are under such pressure that you cannot see your  
own good medical judgment.

Dr. L. W. H. H. Yes, we are under that  
pressure that we have not got time to discuss in detail  
the cases that the doctors are concerned with. It takes  
so much time. A doctor comes in to see you and you have to go  
to a place where he has a case history, to examine the  
patient with him and to discuss it; it is at least 20

minutes. I think the time is well, I  
understand that you are short of your program, but  
even if you are under pressure, you are still under  
the best medical judgment in handling what cases

Dr. L. W. H. H. We are not.

Dr. L. W. H. H. Yes, I think you are a little  
short. If I may be allowed to mention you said a little  
while that there were some good lectures in the program  
is not a good one, especially in some of them.



Lynch

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DR. LYNCH: Well, the good features,  
I think, are that everybody can go to a hospital.

COMMISSIONER McCUTCHEON: Is that a  
good thing?

DR. LYNCH: Personally I do not think  
it is.

COMMISSIONER McCUTCHEON: Then why do  
you say it is?

DR. LYNCH: That is what the public  
feature says.

COMMISSIONER McCUTCHEON: We are  
interested in what you feel.

DR. LYNCH: I would say it is that the  
good feature, if you want to be specific, it is good  
that the poor and indigent and those who are medically  
indigent can now go to hospital and have the best  
facilities without having to worry about the monetary  
aspect. That is good.

I submit, however, this could have been  
achieved with much greater economy of money and manpower  
and would have left autonomy to the hospitals.

COMMISSIONER McCUTCHEON: That is what  
you said earlier?

DR. LYNCH: Yes, sir.

COMMISSIONER FIRESTONE: If I may go for  
a moment to what you say in paragraph 12 on page 1D.  
You say, and I quote:

"It is paradoxical that - at the very  
time when most countries who have  
embarked on socialized medical schemes





Lynch

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are questioning the wisdom and results of these plans - there would appear to be such meretricious party political interest in them in Canada."

Now, I wonder whether you had some evidence in mind when you suggested and used the phrase that "most countries who have embarked on socialized medical schemes are questioning the wisdom" of those plans? I wonder whether I could ask you a specific question: is there any serious suggestion why the start in the United Kingdom to abandon the National Health Plan and to return to the situation as it existed before the introduction of a National Health Plan?

THE CHAIRMAN: Well, there would be two components. It does not necessarily follow that if they abandon they go back to where they were before. You cannot go back to 1948, the calendar prevents you from doing that. This is like asking a boy of 10 if he would like to be 2.

COMMISSIONER FIRESTONE: I was not addressing it in terms of the calendar but to a situation where there would not be a National Health Scheme in existence. You say here, if I understand you correctly, and please correct me if I do not, that most countries who have embarked on socialized medical schemes are questioning the wisdom and results.

I presume that you question it; you would like to see a change. Is there any evidence in support of such an observation?





are questions of this vision and reality  
 in these plans - there is no appeal  
 to be such retrospective party political  
 interest in them in Canada."  
 Now, I wonder whether you had some  
 evidence in mind when you suggested and used the phrase  
 that "about 1900 it was have omitted or socialist  
 social reform and questioning the wisdom" as those  
 of this I wonder whether I could see you a speech  
 a question of the very serious question way the  
 point in the United States to question the wisdom  
 health plan and to return to the situation as it  
 existed before the introduction of a National Health

THE SPEAKER: Well, there would be two  
 elements. It does not necessarily follow that it then  
 allowed them to go back to where they were before. You  
 cannot go back to 1900, the calendar of years was 1900  
 being that. This is like asking a boy of 10 to go back  
 to 1900.

THE SPEAKER: I am not  
 suggesting it in terms of the calendar of years but in  
 that sense would not be a logical return to where it  
 existed. Now say now, as I mentioned, you yourself  
 and I have agreed that it is not, that we have  
 what is an example of a social reform and reality  
 questioning the wisdom and reality.  
 Now, I am sure that you must  
 have seen that it is a social reform and reality  
 that is a social reform and reality.



Lynch

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DR. LYNCH: That is a very complex subject and perhaps that answer is given in one of the sentences of the American Declaration of Independence that all experience showed that mankind is disposed to suffer things as they are rather than to change. That is the sum and substance of it.

Now, the evidence that they are questioning it, there are economists like Lees and Jewkes of Oxford and his wife, these are serious people with no axe to grind and they are questioning the assumptions. You may have read in Reader's Digest recently an article by a man who was closely associated with Beveridge when the scheme was brought in and he wrote an article warning the Americans against establishing this scheme.

As to whether it is possible to change or not, that is another thing and I submit it is not; once a thing becomes law there is a certain sanctity about it and we are more disposed to tinker with it than to change it.

You see, you have broken so many of the natural forces of balance that it is very difficult to go back. Of course, what is always quoted is that the people are happy and that is true; by and large, they are but the people do not know what they are getting.

When a person goes into a doctor's office and the doctor examines her heart, they have not the slightest idea what is going on, whether they are getting good medicine or getting bad medicine; for all they know his stethoscope may be blocked.





Lynch

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However, the frightening thing about these schemes is that they all degenerate into certification schemes. The time is less than 10 minutes for examining a patient which any doctor will tell you is quite impossible on the first visit. On a second visit you can do it but they are really certification.

To come back again to your premise; in Russia there is evidence that they are seriously questioning it. The Minister of Health of the U.S.S.R. is most unhappy about the state of affairs and they have altered their curriculum several times.

Now, he admits that they placed the wrong emphasis on their training; they should have been training general practitioners and now they are coming back to the Western type of medical curriculum. I am sure Commissioner Baltzan, who was in Russia, would be able to tell you more about it than I can.

COMMISSIONER BALTZAN: They have heard so much from me already on that.

COMMISSIONER FIRESTONE: I am very much obliged to you for your views.

COMMISSIONER McCUTCHEON: You believe, I take it, Dr. Lynch, that you can usually consider the nursery rhyme about Humpty Dumpty?

DR. LYNCH: Yes.

COMMISSIONER BALTZAN: I do not want to prolong the discussion but in many briefs we have certain repetitious statements and I would like your personal point of view about this one. They usually say so many countries have partial, to free, to contributory







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Lynch

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national plans; you can count about 20 of them and then they point out that Canada, which is a rich country, has not got one.

They also refer to the United States as another country which has not got a national health plan with the implication that we are behind the times if we have not such a thing.

All the statistics can be shown to prove how much better off these people are than we are without a formal plan.



1967

June

national plans; you can count about 20 of them and

then they come out that Canada, which is a poor

country, has not one.

They also refer to the United States

as a country which has not got a national plan

plan with the implication that we are behind the times

it is not such a thing.

All the criticism can be shown to

only show how better off these people are than we are

without a formal plan.



Lynch

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DR. LYNCH: Well sir I have attempted to produce some statistics in here and they are actually worse off, with the exception of Sweden and New Zealand. If you look into that, you will find Sweden and New Zealand back in 1900 when statistics began to be taken, has always had excellent medical statistics and Sweden, with a fantastically low doctor population ratio, one of the lowest in the world, so much so the Swedes say it isn't the number of doctors that you have, it's the quality of these doctors and the way they are allowed to practise. This is the important thing.

I think again this other thing comes back, sir, to what I wanted to say. There is a big international movement afoot pushing social security from the Federal Government, international labour organizations committed to it and the previous Liberal Government signed the convention in 1952 sir for the advanced social security measures.

COMMISSIONER BALTZAN: If Canada is said to be the 17th lowest in the line of contributing national social security, does that put it in a bad light in the face of the world or could it be reasoned there isn't very much need for it?

DR. LYNCH: I just wish it was about 90th sir. I wish that Canada's position, as regards the level of social security, instead of being 17th, I wish it would be 90th.

I think we would be a lot better off. I think the real answer comes down to something that was produced in the Financial Post, a table analyzing what a





17. I think I have already  
to statistics in here and they are different  
cases all, with the exception of Sweden and New Zealand.  
If you look into that, you will find Sweden and New  
Zealand back in 1970 when statistics began to be taken,  
the things are excellent medical statistics and 3 years  
with a fantastically low doctor population ratio, one  
of the lowest in the world, as much as the United States  
in fact the ratio of doctors that we have, in the  
ratio of these doctors and the way they are allowed  
to practice. This is the important factor.

I think that this other thing comes  
back, also, to what I said to you. There is a life  
international movement and pushing social security  
from the Federal Government, international labour  
organizations committed to it and the previous labour  
movement signed the convention in 1952 and for the  
advanced social security measures.

COMMISSIONER RATTAN: Canada is  
said to be the first country in the line of social security  
national social security, does that not fit in a bit  
first in the line of social security, it is the second  
there is a very good reason for this.  
The United States which is the second  
country. I wish that Canada's position, as we said  
in the line of social security, that is the first, I  
think it is a very good reason.  
I think the world is a lot better off.  
I think the world is a lot better off, as far as  
protection in the social security, a very important thing.



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Lynch P. G. M. 10579

man can purchase with his work. In the United States they are almost twice as good as us.

We are twice better than Sweden which is nearly twice better than Germany which is nearly twice better than England and it is quite fantastic sir.

I think that these people have got organized poverty, a lot of them, but it is organized. Maybe that is what makes them happy. Nobody has any more. They are all poor.

COMMISSIONER BALTZAN: Just depends on which way you look at these statistics.

DR. LYNCH: I don't think any of these countries are any happier sir.

COMMISSIONER BALTZAN: Thank you very much.

THE CHAIRMAN: Which is a good note to stop on Dr. Lynch.

DR. LYNCH: Thank you very much.

THE CHAIRMAN: We will adjourn until 9:30 tomorrow morning.

---ADJOURNMENT.



# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

**TORONTO**

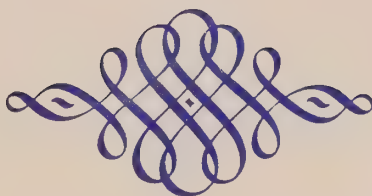
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- ASSOCIATION
- MEDICAL SECTION OF THE CANADIAN  
PHARMACEUTICAL MANUFACTURERS'  
ASSOCIATION
- ONTARIO COLLEGE OF PHARMACY
- CANADIAN ASSOCIATION FOR THE  
ADVANCEMENT OF PHARMACY
- CANADIAN ASSOCIATION OF HOSPITAL



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PHARMACISTS, ONTARIO BRANCH 10727

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings  
held in Toronto, Ontario,  
on the 18th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL --- Chairman

MISS ALICE GILARD, R. N.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE







10580

Upon Resuming at 9:30 A.M.

THE SECRETARY: Mr. Chairman, the first brief this morning is from the Canadian Pharmaceutical Manufacturers' Association to be known as Exhibit 290, 291 and the additional Economic Analysis done for them, dated September 15th, 1960, to be known as 291A.

---EXHIBIT 290, 291: Submission by the Canadian Pharmaceutical Manufacturers' Association.

---EXHIBIT 291A: Economic Analysis of the Canadian Pharmaceutical Manufacturers' Association.

APPEARANCES:

MR. S. N. CONDER

MR. F. R. HUME, Q.C.

THE SECRETARY: Mr. Hume will introduce this brief.

THE CHAIRMAN: Before you say anything, I don't want you to think I am cutting in on you. We have an occasion to remember this morning, and I thought I would just make reference to the fact that it is the birthday of one of our colleagues and these flowers you see are a token, and just a token of our growing regard and affection for him and for the pleasure he has been to us and with us in the past month.

COMMISSIONER McCUTCHEON: Thank you very much, Mr. Chairman.

MR. HUME: Thank you, Mr. Chairman, lady and gentlemen.

THE CHAIRMAN: Mr. Hume, we will invite you to remain seated if you wish.



First time this morning is from the Canadian Pharmaceutical  
Manufacturers' Association to be known as Exhibit 200,  
201 and the additional Economic Analysis done for them,  
dated September 18th, 1950, to be known as 201A.

---EXHIBIT 200, 201:  
Submission by the Canadian  
Pharmaceutical Manufacturers'  
Association.

---EXHIBIT 201A:  
Economic Analysis of the  
Canadian Pharmaceutical Manu-  
facturers' Association.

ANALYST:  
Mr. J. J. Hume, J.C.  
THE SECRETARY: Mr. Hume will introduce

THE CHAIRMAN: Before you say anything,  
I don't want you to think I am cutting in on you. We have  
an occasion to remember this morning, and I thought I  
would just make reference to the fact that it is the  
birthday of one of our colleagues and these flowers you  
see are a token, and just a token of our feeling regard  
and affection for him and for the pleasure he has been  
to be with us in the past year.

CHAIRMAN: Mr. Hume, thank you  
very much, Mr. Hume.

MR. HUME: Thank you, Mr. Chairman.  
And Gentlemen.

MR. CHAIRMAN: Mr. Hume, we will invite  
you to remain seated if you wish.



Hume 10581

MR. HUME: I will take my seat in just a minute. I want to stand to say that my name is F.R. Hume, and that I am appearing as counsel for the Canadian Pharmaceutical Manufacturers' Association and you, having explained as you did a minute ago about the happy event, I would like to add my personal congratulations to Mr. McCutcheon and say it is fitting this Commission should be sitting in his home town on the occasion of his birthday.

The summary and conclusions of the brief which has been filed will be read by Mr. Conder. Mr. Stanley Nesbitt Conder is the General Manager of the Association and he will be answering the questions on it.

MR. CONDER: Thank you, sir.

Canada's pharmaceutical manufacturing industry had its beginning in the mid-1800s. As a result of its continued growth over the years, and its role in providing Canadians with the antibiotics, biologicals, ataractics and other new products which have revolutionized medical science, the industry has come to be recognized as a vital factor in the health of the nation.

It is estimated that manufacturers' sales of pharmaceuticals in Canada now total about \$180,000,000 annually. Some 10,000 Canadians are employed in the industry at a wage and salary bill of approximately \$39,000,000. A total of 28,000 Canadians depend directly on their livelihood from employment in pharmaceutical manufacturing. During the 10-year period ending 1959, salaries and wages increased 93.2 per cent. While not large in comparison with other industries, pharmaceutical







Hume 10582

manufacturing nevertheless is making a worthwhile contribution to employment and the national economy.

From 1958 to 1959, exports declined 29.3 per cent, while imports increased 10.9 per cent. The industry is now in a position to manufacture in Canada most of the nation's requirements for pharmaceuticals, and the majority of drug products sold in Canada are made here. Imports represent about 17 per cent of the total volume of factory shipments. However, a large percentage of the raw materials used in manufacturing must be imported, as the Canadian market is not yet large enough to maintain a fully integrated raw materials supply industry.

Surveys indicate that profits after taxes averaged 5.5 per cent of the sales dollar in 1960, as compared to 6.2 per cent in 1959 and 6.5 per cent in 1958. Average profit for all types of manufacturing in Canada is shown at 4.4 per cent for 1960, which indicates that the profits of pharmaceutical manufacturers are in line with those of other industries. Comparing expenses to profits, it cost 40 major pharmaceutical manufacturers 94.5¢ for every dollar's worth of merchandise sold in 1960.

The industry is now undergoing a period of downward pressure. As a result of the tempo of competition based on discovery and improvement of pharmaceuticals, it is becoming increasingly difficult for even a large company to maintain its position in the market. Accordingly, product obsolescence or the high rate of turnover of new products carries with it a comparatively



Manufacturing performance is leading a remarkable recovery  
in the employment and the national economy.  
From 1933 to 1935, exports declined

The industry is now in a position to manufacture in Canada  
most of the nation's requirements for pharmaceuticals,  
and the majority of drug products sold in Canada are  
made here. Imports represent about 15 per cent of the  
total volume of factory shipments. However, a large  
percentage of the raw materials used in manufacturing  
must be imported, as the Canadian market is not yet large  
enough to maintain a fully integrated raw materials  
industry.

Surveys indicate that profits after  
taxes averaged 5.5 per cent of the sales dollar in 1935,  
as compared to 3.5 per cent in 1933 and 0.5 per cent in  
1934. Average profit for all types of manufacturing in  
Canada is shown as 11.1 per cent for 1935, which indicates  
that the profits of pharmaceutical manufacturers are in  
line with those of other manufacturers. However, compared  
to profits, the cost to major pharmaceutical manufacturers  
of an average of 10 per cent of sales is relatively high.

The industry is now undergoing a period  
of downward pressure. It is a result of the lack of  
competition based on discovery and improvement in phar-  
maceuticals, it is a result of the fact that the industry  
is largely dependent on maintaining its position in the market.  
In addition, product obsolescence on the part of  
manufacturers of new products is a factor in the industry.





Conder 10583

high degree of financial risk for the companies engaged in this field of manufacturing.

As a result of this mortality rate of new products, it is not feasible to judge a company's performance by one or two of its large-volume products. Introduction of a new product by a competitor can cause a company's sales to plummet. In addition, high volume products must help to support the cost of the low volume products. It is interesting to note that pharmaceutical companies carry many "public service" products for humanitarian reasons, and on which the companies lose money or break even on cost.

The competitive aspect of research and development, combined with behaviour of prices and promotional activities, indicates that a satisfactory level of competition exists in the industry. Furthermore, this competition is directed in a manner which is socially desirable. Growth, product development and the general level of prices have been favourable rather than unfavourable to the consumer.

Patents on drugs do not have the same protection that is afforded to other consumer products. This is because of the compulsory licensing provision of the Patent Act. Any one who has the facilities to manufacture a certain drug in Canada, can demand from the owner of the patent a compulsory license to make and sell the drug. Patents do not have a major bearing on drug prices and, because of the competitive factor, no company can inflate price beyond reason regardless of whether the drug is patented or not.





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high degree of financial risk for the companies engaged  
in this line of manufacturing.  
As a result of this monetary risk  
of new products, it is not feasible to judge a company's  
performance on the basis of its large-volume products.  
Introduction of a new product by a competitor can cause  
a company's sales to plummet. In addition, high volume  
products must help to support the cost of the low volume  
products. It is interesting to note that pharmaceutical  
companies employ many "pull services" products.  
Manufacturing seasons, and on which the companies lose money  
of their own cost.  
The competitive aspect of research  
and development, combined with behavior of prices and  
operational activities, indicates that a satisfactory level  
of competition exists in the industry. Furthermore, this  
competition is affected in a manner which is actually  
desirable for growth, but not development and the general  
level of prices have been favorable rather than unfavorable  
to the industry.  
But the companies do not have the same  
position that is related to other chemical companies.  
This is because of the many very different reactions  
to the market. Any one of the facilities to which  
there is a reaction may be a catalyst, but the only  
of this market is very different from the other and will be  
that the market is not a reaction to the market as a whole  
and, therefore, of the non-reaction to the market as a whole  
and the market is not a reaction to the market as a whole  
and is related to the market as a whole.



Conder 10584

Advertising and promotion are important to the distribution of pharmaceuticals. An efficient information service is vital to the health of the nation. Even the most effective drug available would be worthless if the medical profession did not know of the drug's availability or therapeutic actions. Physicians must be kept informed of the development of new pharmaceuticals and reminded of the many types of preparations available. Companies do not spend money unnecessarily, and experience has shown that the most effective means of keeping the physician informed is through journal and direct mail advertising and the use of professional service representatives.

Selling prices of drugs at the manufacturers' level are most reasonable and retail prices are within the means of the average Canadian's purchasing ability. Family expenditures for prescription drugs are relatively minor in comparison to expenditures for luxury and non-essential items. Even in the case of chronic illness, the weekly cost to the patient of most drugs is considerably less than the cost of cigarettes to the smoker.

The consumer index for prescriptions has not risen as high as it has for items such as food and housing, which are equally important to the health and well being of Canadians. Furthermore, the consumer price indexes for all other items of health care have risen more rapidly than that for prescriptions.

At December, 1961, the consumer price index for prescriptions was only 2.3 over the 1949 level.







Conder 10585

At October, 1961, weekly wages in manufacturing had risen to \$81.3 which leads to the conclusion that the Canadian worker can better afford to buy drugs today than he could in 1949. Prices of drugs in Canada are actually low in relation to the comparable purchasing power of the average Canadian. If a problem does exist in this area, then it is with a small percentage of the population which, for reasons of substandard income or chronic illness, finds it difficult to purchase all commodities and services including drugs.

The manufacturer gets approximately 50 per cent of the retail price of a prescription. There is an 11 per cent sales tax applied at the manufacturers' level on retail prices of pharmaceuticals. This does not apply to purchases by most hospitals. The primary reason for the difference between hospital and retail prices is the economics involved in manufacturing and selling bulk to institutions as against manufacturing and selling small consumer-size packages through thousands of retail outlets from coast to coast.

Prices of pharmaceuticals at the manufacturers' level in Canada compare favourably with world prices. Studies indicate that Canadian prices are below the average for many other nations.

Quality control in the manufacturing of pharmaceuticals is of paramount importance. Good quality is not merely a matter of product excellence, but an absolute requirement of modern medication. It is not something which can be determined by assay of the end product, as the quality must be built into the product





Conclusion

In October, 1941, weekly wages in manufacturing had risen to 61.3 which seems to the Commission that the Canadian worker was better off than in any other country in the world. Prices of drugs in Canada are actually low in relation to the comparable purchasing power of the average Canadian. If a program were exist in this area, then it is with small percentage of the population who, for reasons of substantial income or chronic illness, find it difficult to purchase all necessities and services including drugs.

The Canadian drug formulary is a list of the retail price of a prescription. There is an 11 percent sales tax applied to the Canadian formulary level on retail prices of pharmaceuticals. This does not apply to purchases by most hospitals. The primary reason for the difference between hospital and retail prices is the account is involved in manufacturing and selling bulk to institutions as against retailing and selling small quantities to druggists. The Canadian formulary is a list of the retail price of drugs.

Prices of pharmaceuticals in the United States are generally lower than in Canada because of the competition with foreign prices. Studies indicate that the foreign prices are below the average for the United States. The reason for this is that the United States is a large market for drugs and the manufacturers are not merely a matter of product specialization. It is not an industry in itself of medical specialization. It is not a matter of the quality of the product but the price of the product, as the quality of the product is not the primary factor.



Conder 10586

during manufacture. For this reason, the reputation of the manufacturer is based on the reliability of his products.

It is absolutely essential that a drug do the specific task required, with a minimum of side effect. There can be no margin of error for the physician, for the pharmacist - or for the patient.

A physician gains through experience a knowledge of the reactions certain products have on his patients. It is recognized that in some cases the choice of a certain manufacturer's product is as important as the choice of the actual therapeutic agent. While competing products may be similarly labelled as to content, they do not necessarily provide similar physiological responses in patients. A trade name has implications beyond commercialism. Consequently, to deny the physician the right of prescribing the drug of his choice would, in effect, take the welfare of his patients out of his hands.

A manufacturer or importer who wants to cut corners by reducing manufacturing control costs can do so, for there is at present no law in Canada requiring extreme diligence in control procedures. Such laws could be introduced, and we are presently working closely with the Food and Drug Directorate on regulations in this area, but it would be virtually impossible for any government agency to test every batch of drugs sold in Canada. In pharmaceutical manufacturing, the reputation of the maker is still the best test of product reliability.

Some pharmaceuticals purchased by our hospitals under generic name have been found to be sub-standard. A manufacturer selling under trade name, cannot afford this type of risk.



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The standard of the industry is based on the reliability of the

It is essential to establish that a

to the specific task required, with a minimum of time  
effort. There can be no margin for error for the physician  
for the pharmacist - or for the patient.

Physician, the patient, pharmacist

A number of the conditions described above are  
which is recognized that in some cases the only  
of a certain number of a product is as good as the  
of the drug, the pharmacist, the physician, the patient

product, the patient, the physician, the pharmacist, they

do not necessarily provide similar protection to the

in addition, the patient, the physician, the pharmacist

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right of prescribing the drug of his choice would be

take the safety of his patient out of his hands.

A physician of tomorrow will be

can do so, for there is no provision for the patient to

ing extra charges in the form of a surcharge, or

could be introduced, and we are presently working on

with the Food and Drug Administration on regulations

this way, but I would like to have a word to say

government agency, or even a committee of the

and in the case of the patient, the physician, the pharmacist

of the drug, as still the best test of the reliability

State, the patient, the physician, the pharmacist

of the drug, the patient, the physician, the pharmacist

of the drug, the patient, the physician, the pharmacist





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Pharmaceutical manufacturers sell most of their products under trade names and in time, through advertising and performance, these products become known and accepted by the medical profession. Consequently, manufacturers or importers dealing almost exclusively in generic names, sell their products as a direct result of the demand created by and for the trade name products. If all drugs could be sold under generic name alone, and this is impractical in many cases, it would eventually squeeze out the smaller companies and thus curtail competition in the industry.

If price alone became the criterion for selling drugs in Canada, it would not be in the best public interest. It is doubtful whether the public would stand for any measure which demanded that the cheapest medication be sold without regard for the reputation of the maker. It is for this reason that the merchandising of cut-rate or discount products, prevalent in other industries, has not made any serious impact on the field of drugs. Canada's pharmaceutical manufacturers have been able to compete with imports because of the known reliability of our companies, the consistent quality of our products, and the fact that most Canadians when ill prefer the finest medication available.

The pharmaceutical manufacturing industry's phenomenal growth in recent years has been the result of the competitive introduction of new products rather than increases in prices of older substances. While small in size, the industry is doing a creditable amount of research and development. Some of the work





October 1934

Pharmaceutical manufacturers are not  
of their products under trade names and in time, through  
experience and performance, these products become known  
and accepted by the medical profession. Consequently,  
manufacturers on incentives leading almost exclusively  
in generic names, sell their products as a clinical product  
of the demand created by and for the trade name products.  
If a drug could be sold under generic name alone,  
and this is hypothetical in many cases, it would eventually  
squeeze out the smaller companies and the curb of  
competition in the industry.

If a drug alone became the criterion  
for selling drugs in Canada, it would not be in the best  
public interest. It is doubtful whether the public would  
stand for any medicine which demanded that the physician  
medication be sold without regard for the reputation of  
the maker. It is for this reason that the new marketing  
of a drug on different products, prevalent in other  
countries, has not made any serious impact on the trade  
of a drug. Canada's pharmaceutical manufacturers have  
been able to cope with the adverse effects of the known  
refinement of our companies, the excellent quality of  
our products, and the fact that most Americans when they  
need the finest medication available.

Industry's phenomenal growth in recent years has been the  
result of the combination of new products  
rather than increases in sales of older products.  
While sales in this industry are growing rapidly,  
the amount of research and development work done in the



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undertaken in Canada by these companies has been significant. Certain companies now have large research laboratories in Canada. Others are commencing to establish research facilities, while still others are contributing experience and finances to Canada's independent researchers and universities.

Research work involved in new discoveries and improvements in older products is costly, time-consuming and largely the result of countless previous failures. In 1960, the percentage of total cost of all research and development in relation to net sales for 35 Canadian companies was 8.3 per cent. As the population of Canada grows and the market for pharmaceuticals expands, the industry will be able to increase its research facilities accordingly.

Equally important to research, is the need to find means of producing drugs so that they may become widely available. This is one of the industry's primary responsibilities. The most expensive drug in the world is the one which lies dormant in the laboratory.

Drugs discovered by pharmaceutical companies have helped reduce the cost and duration of illness, thereby contributing to the welfare of the patient and the economy of the nation. In fact, thousands of Canadians living today owe their lives to the new pharmaceuticals discovered within the past 15-20 years.

These newer drugs have also helped to shorten the length of stay in hospitals, yet they have not been a major factor in increasing costs of hospital services. In 1958, drugs accounted for only 4.8



Order

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Research work involved in new discoveries  
and improvements in older products is costly, time-consuming  
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In 1965, the percentage of total cost of all research  
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to continue the battle against disease, yet the  
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drug. In fact, the industry has a reputation for being



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per cent of the total expenditures of 852 Canadian hospitals. Spiralling costs of health care are a direct reflection of the general rise in the economy of the nation. Canada must be careful that attempts to reduce costs at the hospital level are not done at the expense of the patient's health.

Only quality pharmaceuticals from reputable manufacturers should be purchased and utilized. False economy harms only one person, the patient. No thinking Canadian wants second-best medication. When he is at home, he can ensure that his family physician and pharmacist prescribe and dispense for his family the finest drugs available. He should have this same assurance while in hospital, and this can best be done by leaving the freedom of choice in the hands of the physician.







Conder

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Substitution is not a practical method of securing economies in the drug bill.

The members of Canada's health team have a responsibility to safeguard the health of the people. The people, in turn, have a responsibility to maintain a climate conducive to enabling the health team to continue to provide the highest standard of medical services available. In finding a solution to the problem of those who may not be able to afford certain medical services, any system which might tend to reduce the high quality of services now available to the majority of the people should be avoided.

In the field of pharmaceuticals, an extensive study of the precise area of need is required before the role of drugs in any extension of our health services can be determined. In this respect, our Association is willing to work closely and in wholehearted co-operation with the Commission or any other government agency which may be assigned this responsibility.

#### RECOMMENDATIONS

Based on the foregoing, it is recommended:

1. That it be made mandatory that no drug be offered for sale in Canada unless it has been manufactured under controlled conditions, by or under the supervision of qualified personnel, and that representative samples of each and every batch of products be tested for potency and safety by the manufacturer before release. In other words, the high standards of pharmaceutical manufacturing attained by most Canadian manufacturers should be made compulsory for all engaged in the





Conder

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3 industry, and these same standards should also apply  
4 to drugs manufactured abroad and offered for sale in  
5 Canada. Furthermore, the cost and onus of responsibility  
6 for the quality and therapeutic effectiveness of medica-  
7 tion should be placed on the supplier and not on the  
8 government.

9                   2. That, beyond this primary recommen-  
10 dation, the Canadian pharmaceutical manufacturing  
11 industry be allowed to continue to operate without undue  
12 restrictive legislation. The sanctity of trade marks  
13 and the reasonable degree of protection afforded inven-  
14 tors by the Patent Act are as important to a healthy  
15 pharmaceutical manufacturing industry as they are to  
16 other sectors of the economy. Such important property  
17 rights should be withheld only if there is real evidence  
18 of abuse within the intent of the legislation. Attempts  
19 to legalize substitution through the dispensing of  
20 products other than those prescribed by physicians  
21 should not be permitted, as such a system is definitely  
22 not in the best public interest.

23                   3. That, if necessary, legislation be  
24 designed to encourage the continued development of a  
25 self-supporting Canadian pharmaceutical manufacturing  
26 industry, on the premise that a healthy industry is  
27 important to the welfare of the nation. This leads to  
28 a recommendation that the government study the practica-  
29 lity of providing incentives to the chemical industry  
30 in order to establish more facilities in Canada for  
producing the raw materials used in pharmaceutical  
manufacturing.





industry, and these same standards should also apply to drugs manufactured abroad and offered for sale in Canada. Furthermore, the cost and ease of responsibility for the quality and therapeutic effectiveness of medicines should be placed on the producer and not on the consumer.

2. That, beyond this primary responsibility, the Canadian pharmaceutical manufacturing industry be allowed to continue to operate without undue restrictive legislation. The security of trade marks and the reasonable degree of protection afforded inventors by the patent law are as important to a drug manufacturing industry as they are to other sectors of the economy. Such important property rights should be withheld only if there is real evidence of abuse within the intent of the legislation. Attempts to regulate distribution through the dispensing of products other than those prescribed by physicians should not be permitted, as such a system is contrary to the best public interest.

3. That, if necessary, legislation be introduced to encourage the continued development of a self-sufficient Canadian pharmaceutical manufacturing industry, on the basis that a healthy industry is important to the welfare of the nation. This factor is particularly true in the Government's study and promotion of new products and processes in the pharmaceutical industry. In order to be successful, the industry must be able to attract new capital and new talent. The Government should encourage the pharmaceutical industry to continue to develop and improve its products and processes.



Conder

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A fully integrated pharmaceutical industry embracing research and development is important to the scientific emancipation of any nation. For one thing, it employs a relatively large number of scientific personnel and provides job opportunities at home for university graduates in contrast to having them seek such opportunities elsewhere.

4. That a detailed socio-economic study be undertaken by the Commission, similar to that of the National Sickness Survey, to determine the area of indigency having regard not only to the incidence of chronic conditions requiring medical care over long periods of time, but also to the true inability of the patient to pay for such care. Based on the results of such a study, ways and means should be found to provide assistance for the needy which are not provided for through government welfare or private prepayment plans.

In conclusion, there can be no doubt that the drugs made available by Canada's pharmaceutical manufacturers have been a major factor in helping to reduce human suffering and eradicate disease and illness. The industry is operating in the best public interest, its profits are not unusually high but consistent with good business practice, and prices are in line with the purchasing ability of the average Canadian.

It is offered that strong domestic industry is important to the future of our nation, partly as a means of retaining national productivity and employment, and primarily to meet the future medical needs of Canadians in all walks of life.







Conder

10593

This brief is respectfully submitted.

THE CHAIRMAN: Thank you very much, Mr. Conder. I think it is quite proper that I should say at this time that the Commission has had the very best co-operation from the Canadian Pharmaceutical Manufacturers' Association. As you know, we submitted a questionnaire in which we asked for much information and the type of information that required a lot of statistical studies and so forth to complete.

We want to accord our appreciation for the co-operation in that regard. I say that now because in the discussion this morning questions may be put that may lead you to think that we have, perhaps, not as high a regard of your industry as I have just indicated in what I said. That is not the intent. The questions are not put from any basis of that kind, but to develop a discussion here that may be of assistance to us in appreciating the whole subject of drug prices, because, rightly or wrongly, it is a subject that apparently is regarded with considerable interest by government and by the public.

Perhaps I might start off by making what may appear to be a provocative statement because I want your reaction to it. It has been suggested to us that the prescription, cost of prescription drugs to Canadians in any of the recent years, is in the order of about \$200,000,000 a year. Actually we had a statement from the Green Shield project in the Windsor area that would lead us to believe the cost to be considerably higher. In any event, this figure of \$200,000,000 is





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THE CHAIRMAN: Thank you very much.

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as high a regard of your industry as I have just indicated

in what I said. That is not the intent. The questions

are not put from any basis of that kind, but to develop

a discussion here that may be of assistance to us in

approaching the whole subject of drug prices, because,

right or wrong, it is a subject that certainly is

related to the general interest of government and

by the public.

Perhaps I might just say that

and may appear to be a provocative statement to make

in your reaction to it. It has been suggested to

us that our description, so far as the drug industry is

concerned in any of the recent years, is in the order

of about 50,000,000 a year. I would like to state that

from the Federal child project in the United States last

year, that is to say, the cost to be borne by the

Federal Government in any event, this figure is about \$1,000,000,000.



Conder

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one that is a very respectable one, in size, in any event. It has been said that about 10% - that is retail cost, the cost to the consuming public, the \$200,000,000.

In your submission here this morning you say the manufacturers receive about 50% of the retail cost, so what we are advised in in terms of manufacturing costs is about \$100,000,000. It has been represented that the drug industry actually manufactures in Canada about 10% of the total volume of drugs sold in Canada and imports and package the balance, and the drug industry is, in fact, a packaging industry rather than manufacturing. I am only speaking of prescription drugs in that \$200,000,000.

MR. CONDER: Do you wish me to comment on that, sir?

THE CHAIRMAN: If you would. I opened the subject broadly for you. I know that you deal with it in the first point you make in your summary and recommendations.

MR. CONDER: On the statement of the fact that 90% of the pharmaceuticals...

THE CHAIRMAN: I wouldn't want you to take 90% of the figure distinct from some other figure in the same range.

MR. CONDER: I will venture this, that the majority of products, ethical pharmaceuticals sold in Canada today, are manufactured here according to our terms of reference.

THE CHAIRMAN: Well now, that is the



1952. London.

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MR. COOPER: Do you wish me to comment

on that, sir?

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MR. COOPER: On the statement of the

fact that 90% of the drugs are imported.

MR. CHAIRMAN: I wouldn't want you to  
take 90% as the figure of import from some other figure  
in the same range.

MR. COOPER: I will return this,

that the majority of products, ethical pharmaceuticals  
sold in Canada to my knowledge are imported  
to our kind of patients.

MR. CHAIRMAN: Well, now, that is the



Conder

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start; what are the terms of reference? What do you call manufacturing?

MR. CONDER: Manufacturing constitutes the taking of the raw materials, which may be the active ingredients in the case of compounded substances, it may be two or more active ingredients plus fillers and other materials which must go in to the finished product. They are placed into the plant, combined, manufactured into the final dosage form. It is the dosage form that the patient takes and not the raw chemical form or the active ingredient.

In some cases, the active ingredient could be taken by the patient direct, but it must be completed, manufactured and placed in the dosage form. According to the figures submitted by the Dominion Bureau of Statistics, 17% of pharmaceuticals sold in Canada are imported.

COMMISSIONER McCUTCHEON: You mean imported in finished form?

MR. CONDER: They just use the straight figure on imported.

THE CHAIRMAN: You see, we are trying to get a little more refinement into those figures. The operation you describe might be called...

MR. CONDER: I have commented, Mr. Chairman, on this in detail in the brief; if I may just find the section here.

THE CHAIRMAN: What you may be doing, what you are calling manufacturing may well be an assembling and mixing process.





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and what are the terms of reference? What is your

understanding of the

the taking of the raw materials, which may be the

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MR. COMPTON: You see, we are trying to

put a little more definition into these figures. The

operation you describe would be called...

MR. COMPTON: I have commented, Mr.

Chairman, on it in detail in the brief; if I may just

add the section here.

The Chairman: What you may be doing,

what you are calling manufacturing may well be an

assembling and mixing process.



Conder

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MR. CONDER: You mentioned when you were commenting on this that the goods were manufactured and some packaged here. Packaging, in our terms of reference, does not constitute manufacturing. It is the taking of raw materials and placing them into finished dosage forms that constitutes manufacturing because raw materials are not suitable for medication until they have been completely placed into dosage form.

THE CHAIRMAN: I don't want to argue, but could it be said to be assembling? A wheel, tire and so forth is not an automobile, it is the assembling, the bringing together that makes the automobile and yet the automobile would not be manufactured in that sense.

MR. CONDER: It could be considered manufacturing or processing; by the same token, sir, that wheat that is taken from the farm is the raw material that goes into a loaf of bread, but the loaf of bread does not exist until it is taken out and processed or manufactured into final form.

COMMISSIONER BALTZAN: Could we just use one I am going to mention purely for illustrative purposes and that would probably bring us down to the question the Chairman has put to you.

Take digitoxin, or any other one; there is a question of extraction. Is that done in Canada? Are most of these things done in Canada or do you import it? Along with the extraction goes the purification and then comes preparation and then comes combining and



Mr. Oliver: You have said when you

were considering on this that the goods were manufactured  
and some of them were in the hands of the  
reference, does not constitute manufacturing. It is  
the taking of raw materials and placing them into  
finished goods. It seems that constituted manufacturing  
because raw materials are not suitable for distribution  
until they have been completely placed into shape.

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Mr. Oliver: I don't want to argue,

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and so forth is not an article, it is the assembling  
the things together that make the automobile and  
yet the automobile would not be returned in that

Mr. Oliver: It could be considered

manufacturing or processing by the same thing, in  
that what is taken from the raw is the raw  
material that goes into a final product, but the  
of final is not final until it is taken out  
processed or manufactured into final.

Mr. Oliver: I should like

now one I am going to mention purely for illustrative  
purposes and that would probably bring us down to the  
position the chairman has put to you.

Mr. Oliver: On any other one; I

is a question of definition. Is that what in Canada  
the most of these things that in Canada or in the United  
States and the question goes the same way  
and then comes, conversation and that comes down to you



Conder

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then comes the packaging. How much of this total process, the five steps, is done in a primary product like that?

MR. CONDER: It depends primarily on the type of product, Doctor, as you pointed out. We approached all companies to ask them on this point. We said we considered the raw materials which are taken in bulk form into a centering point at the plant and put into the receiving area at the plant as a raw material and the manufacturing end of the company takes the raw materials out of the processing department and puts them through various operations in the plant area.

COMMISSIONER BALTZAN: Is the raw material here the foxglove that may come in the barrel or the bag and really start from there?

MR. CONDER: It could, depending on the company and the type of operation.

COMMISSIONER BALTZAN: From there you call it processing?

MR. CONDER: Most of our products today, you will appreciate, are synthetic chemicals.

COMMISSIONER BALTZAN: Yes.

MR. CONDER: In some cases, these synthetic chemicals, in order to produce the basic ingredient, requires a considerable investment and a very sizeable operation. This part of the operation applies to the chemical industry and not to our industry. We buy from the chemical industry. That is raw material.

COMMISSIONER BALTZAN: The synthesized product, that is then your raw material?





then comes the packaging. Now much of this total process, the five steps, is done in a primary product

Mr. [Name] is dependent primarily on the type of product, but, as you pointed out, we cannot get all companies to ask them on this point.

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and the manufacturing end of the company takes the raw materials out of the processing department and puts them through various operations in the plant area.

Mr. [Name] said: Is the raw material that the company that may come in the barrel

on the day and really start from there?

Mr. [Name]: It could, depending on the company and the type of operation.

Mr. [Name] said: But I think you call it processing?

Mr. [Name]: Most of our products today, you will agree, are synthetic materials.

Mr. [Name] said: In some cases, there

without chemical, in order to produce the basic material, we have a considerable investment and a very sizeable operation, and part of the operation

applies to the chemical industry and not to our industry. We say that the chemical industry is the raw material.

Mr. [Name] said: But you are not really



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MR. CONDER: That is right, sir, and  
frankly, as we have mentioned in our brief, in many  
cases the actual cost of the raw material itself is a  
small part of the cost, manufacturing cost, of the  
final product.



Mr. C. W. ... it is right, sir, and

... the actual cost of the raw material itself is a

... part of the cost, ...

... final product.



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4 COMMISSIONER BALTZAN: How much of  
5 this chemical work is being conducted in Canada?

6 MR. CONDER: Again it depends on the  
7 companies and type of product. I would generally say  
8 that the majority of basic chemicals, raw materials  
9 are imported into this country for the simple reason  
10 that Canada does not have the market for the volume  
11 sufficient to maintain the rather extensive chemical  
12 production facilities required to make this type of  
13 material.

14 COMMISSIONER BALTZAN: And a lot of  
15 these primary chemical products are patented are they?

16 MR. CONDER: They may or may not be.  
17 It depends on the product.

18 COMMISSIONER BALTZAN: Would a large  
19 proportion of them be patented? I mean, to the extent  
20 that it raises the cost to you?

21 MR. CONDER: Well, frankly sir we  
22 doubt whether the patent factor in a product, even at  
23 the chemical end, is a sufficient one to affect the  
24 price to the consumer to any measurable degree for this  
25 reason. That, as we have mentioned, in most cases one  
26 of the lowest cost factors involved in producing a  
27 drug is the raw material. Now, there are exceptions  
28 to that of course but in most cases that is true.

29 COMMISSIONER FIRESTONE: Would you  
30 say that many of the materials that are imported, which  
you call raw materials, are really processed materials?

MR. CONDER: What do you mean by  
processed materials Doctor?







Conder

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COMMISSIONER FIRESTONE: You used the phrase yourself in the sense, I think, in the discussion of processed materials before. Processed materials mean materials that have undergone some transformation from the original form in which they have been created.

MR. CONDER: Well, it may be so, because if you look at chemical synthetics for example, and most products on the market today are produced by a chemical synthesis, it would have to be that these products would have to come in in some processed form, because it would be an impossibility to submit raw carbon for example without having some break-down from it.

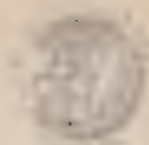
COMMISSIONER FIRESTONE: Well, we are grateful for this information because we are mostly talking of processed materials, rather than raw materials. Raw materials have a commonplace kind of connotation, and you have explained to us that most of these materials coming in are processed materials?

MR. CONDER: ; They could be. ; They are raw materials for industry.

COMMISSIONER BALTZAN: They are finished products as far as the chemical companies are concerned, but they are raw materials upon which you then begin to work?

MR. CONDER: That is right.

THE CHAIRMAN: Do you change the nature of that raw material, as you call it, or do you merely combine it with other things without changing the nature of any of it?



COMMISSIONER FIRST: Yes, I see the

change yourself in the case, I think, in the discussion

of processed materials before. Processed materials

and materials that have undergone some transformation  
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MR. CONNER: Well, it may be so,

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MR. CONNER: They could be. They are

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COMMISSIONER FIRST: They are

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concerned, but they are raw materials upon which you

then build up work.

MR. CHAMBERLAIN: Do you change the

name of that raw material, or you call it, or do you

simply continue it with other names without changing

the nature of any of it?



Conder

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MR. CONDER: It depends again, sir, on the product. In the case of a single active ingredient in a product, you might combine this with other materials.

THE CHAIRMAN: And the other materials might be water?

MR. CONDER: Or for various fillers, various processing operations, in order to make this product become effective. In the case of timed disintegration, for example, where a patient is expected to take a specific drug, and have that drug do possibly two or three things in the patient's body at the same time, it requires a different time of disintegration. It might be a product the patient might take where they want one element in the drug to disintegrate in two hours, one in six hours, and one in eight hours. This has to be carefully built into this product. The ingredients themselves are worthless without the disintegration.

THE CHAIRMAN: I think one would have no difficulty in accepting that as a manufacturing process.

MR. CONDER: Yes sir. You mentioned the case of adding water of course.

THE CHAIRMAN: I was just trying to find a very simple substance, a filler, I don't know what filler might be, but there must be a number of very innocuous fillers?

MR. CONDER: There are some, but we have here an example of a case such as water for example,





Mr. COLEMAN: It depends again, sir,

on the product. In the case of a simple active ingredient in a product, you might combine this with other materials.

THE CHAIRMAN: And the other materials

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THE CHAIRMAN: I know one would have no difficulty in accepting that as a manufacturing

Mr. COLEMAN: Yes, sir, you are right. The case of slow water or oil.

THE CHAIRMAN: I was just trying to find a very simple illustration. I don't know what filter might be, but there must be a number of very important factors.

THE CHAIRMAN: There are some factors

have here an example of a case such as this, for example,



Conder

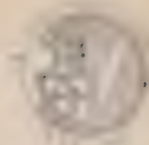
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3 which is used for injection purposes. Water is probably  
4 the cheapest raw material that we have available to us,  
5 but it would be a case of taking tap water and purifying  
6 this water, packaging it, sterilizing it, injecting it  
7 for sterility into rabbits, rejection of lots found  
8 unsatisfactory in quality control and in the processing.  
9 Even this distilled water must be tested for organic  
10 and inorganic impurity, and the containers must be  
11 tested biologically before filling. It must be  
12 injected into rabbits. Then the ampoules must be  
13 immersed in a dye bath to find if there are any cracks,  
14 and if so they must be destroyed. This must be done  
15 with every ampoule sold, because the contents go into  
16 a patient's veins. If it meets all these requirements  
17 it is released for sale to the hospital, and these  
18 ampoules sell for about ten cents.

18 THE CHAIRMAN: Yes, I understand that  
19 process, which you detailed in detail in the brief.  
20 That was not the sense in which I was using water, as  
21 just an additive, because as we go into a drug store  
22 to get a prescription filled, and the odd time that one  
23 is compounded you see the druggist take a big jar  
24 marked distilled water, and just pouring in so many  
25 ounces of it. That is what I call a filler of water.

25 MR. CONDER: A filler can be used for  
26 various reasons. For example, in your timed disintegra-  
27 tion ---

28 THE CHAIRMAN: I don't want to go  
29 into it. I was just using that as one of the things  
30 that might happen, but your position is that the suggestion



which is used for injection purposes. Water is probably the cheapest raw material that we have available to us, but it would be a case of taking tap water and purifying this water, packaging it, sterilizing it, injecting it for sterility into vials, rejection of lots found unsatisfactory in quality control and in the processing. Even this distilled water must be tested for organic and inorganic impurity, and the containers must be tested biologically before filling. It must be injected into rabbits. Then the responses must be measured in a dye bath to find if there are any cracks, and if so they must be destroyed. This must be done with every ampoule sold, because the contents go into a patient's veins. If it meets all these requirements it is released for sale to the hospital, and these ampoules sell for about ten cents.

THE CHAIRMAN: Yes, I understand that

process, which you detailed in detail in the brief. That is not the sense in which I was asking water, as just an additive, because as we go into a drug store to get a prescription filled, and the odd time that one is concerned you see the pharmacist take a big jar marked distilled water, and just pouring in so many ounces of it. That is what I was filled of water.

THE CHAIRMAN: A filler can be used for various reasons. For example, in your typed statement

tion ---

THE CHAIRMAN: I don't want to go

into it. I was just asking that as one of the things





Conder

10603

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3 that I put to you is completely unfounded?

4 MR. CONDER: Yes sir, it is. We have  
5 heard this statement presented in the past. It has  
6 been stated that the majority of drugs in Canada have  
7 been brought into Canada and merely packaged here.

8 THE CHAIRMAN: Majority is another  
9 word I want to deal with. Are you speaking of items,  
10 because you will realize there may be a thousand  
11 inexpensive items, counter-balanced by two or three  
12 expensive and valuable items.

13 MR. CONDER: Yes sir, we asked our  
14 drug companies to advise us as to their break-down of  
15 total volume of sales, and we found that the great  
16 majority of them are actually made in Canada. In our  
17 brief we state that a survey conducted in 1960 indicated  
18 that a survey of firms show that 94% of their products  
19 are made here, and they import only 6%.

20 THE CHAIRMAN: And by majority you  
21 were saying of course that is in terms of sales?

22 MR. CONDER: In terms of sales or  
23 volume.

24 THE CHAIRMAN: Which is of course a  
25 true way of gauging the amount of imports.

26 MR. CONDER: Yes sir it is. We found  
27 that Clarkson, Gordon and Company for example surveyed  
28 40 firms in 1960, and this included non-manufacturing  
29 companies. 81.5% of the total sales volume was  
30 manufactured and packaged in Canada. Then we broke that  
down further, and said 11.8% is made outside of Canada  
but packaged here, while 6.7% was manufactured and  
packaged in other countries. Now, on your packaging





that I put to you is completely unfounded?

MR. COCHRAN: Yes sir, it is. We have

heard this statement presented in the past. It has been stated that the majority of drugs in Canada have been brought into Canada and rarely packaged here.

THE CHAIRMAN: Majority is another word I want to deal with. Are you speaking of items, because you will realize there may be a thousand inexpensive items, counter-fainted by two or three expensive and valuable items.

MR. COCHRAN: Yes sir, we asked our drug companies to advise us as to their break-down of total volume of sales, and we found that the great majority of them are actually made in Canada. In our brief we state that a survey conducted in 1960 indicated that a survey of firms show that 94% of their products are made here, and their import only 6%.

THE CHAIRMAN: And by majority you were saying of course that is in terms of sales?

MR. COCHRAN: In terms of sales or volume.  
THE CHAIRMAN: Which is of course a true way of measuring the amount of imports.

That Clarkson, Gordon and Company for example surveyed 40 firms in 1960, and this included non-manufacturing companies. 81.5% of the total sales volume was manufactured and packaged in Canada. Then we broke that down further, and said 81.5% is made outside of Canada but is packaged here, while 6.5% was manufactured and packaged in other countries. Now, on your packaging



Conder

10604

operation you have roughly 18% of the products that were brought in and manufactured or brought in in dosage form and packaged here.

COMMISSIONER FIRESTONE: Would many of the firms that are not covered in the Clarkson, Gordon survey be importing?

MR. CONDER: Yes, a considerable number of them would be, but I would venture that the 40 companies represented here, and this could be obtained from their figures, do the large bulk of the business in Canada dollar-wise.

THE CHAIRMAN: On page 100, Mr. Conder, you introduce just a new word, a new phrase:

"It is interesting to note that

"pharmaceutical companies carry many

"'public service' products ---".

Could you expand that? Just what do you mean by that expression.

MR. CONDER: A public service product would be a product which a company might discover as the result of some research operation. In looking for a new substance they may find a product which has a very limited use.

THE CHAIRMAN: Can you name one? It is the naming of the thing that makes this very ---

MR. CONDER: Probably the most popular one would be Antivenin, which is an anti-snake bite remedy. A few people die of snake bite in Canada today. If I may just refresh your memory sir. In this case on page 30 in our presentation we state that:





Conder

10605

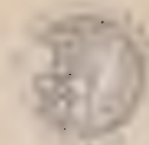
"A by-product of this competitive  
"activity ---",  
and this is in reference to research:

"--- produces these 'public service'  
"products products carried by  
"pharmaceutical manufacturers, and on  
"which they actually lose money or  
"break even on cost. Some of these  
"products are actually given away free.  
"These are primarily products discovered  
"in pharmaceutical laboratories which  
"have a limited use in that they are  
"often for rare diseases or ailments.

"In many cases these public  
"service products are the result of  
"extensive research, but for a variety  
"of reasons have a small demand.  
"Aldosterone is an excellent example.  
"Used to combat diminished or absent  
"adrenal function, this mineralocorticoid  
"was isolated and synthesized by a  
"pharmaceutical company. While of  
"major physiological importance, it  
"has as yet a limited therapeutic use.

"Another company did considerable  
"research on a product known as Releasin  
"only to find that it is extremely  
"difficult and costly to manufacture.  
"Initially used in threatened abortion,  
"it has now been found helpful in





and this is in reference to research:

"--- produce these 'public services'

"products produced carried by

"pharmaceutical manufacturers, and on

"which they actually lose money on

"these even on cost. Some of these

"products are actually given away free.

"These are primarily products discovered

"in pharmaceutical laboratories which

"have a limited use in that they are

"often for more diseases or ailments.

"In many cases these public

"service products are the result of

"extensive research, but for a variety

"of reasons have a small demand.

"Altho there is an excellent example,

"used to combat diphtheria or scarlet

"fever, this is a remarkable

"was isolated and synthesized by a

"pharmaceutical company. While of

"major pharmaceutical importance, it

"has as yet a limited therapeutic use.

"Another company did considerable

"research on a product known as B-12

"only to find that it is extremely

"difficult and costly to manufacture.

"Initially used in the treatment of anemia,

"it has now been found helpful in



Conder

10 606

"alleviating scleraderma, a rare disease  
"causing hardening of the skin and for  
"which there is no known cure. The  
"company loses money every time it  
"makes a sale of this product. Still  
"another company produces a chemothera-  
"peutic agent called 5 FU. Administered  
"in the treatment of certain cancers,  
"it is given free to qualified  
"clinicians."

Skipping a paragraph there, there is:

"A product known as Lofenalac is  
"truly a life-saving boon to sufferers  
"of phenylketonuria. This is a rare  
"disease of children which, if untreated,  
"will eventually cause permanent and  
"fatal damage to the brain. Fortunately  
"this disease can be easily detected  
"and, if determined in the early stage,  
"the brain damage can be prevented by  
"the use of this product, permitting  
"the child and later the adult to  
"live a normal life. This is the  
"only product of its kind available in  
"Canada, yet the company makes it  
"available at cost, taking no profit  
"whatever on the product."



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"Alleviating colic, a more severe  
"disease, narrowing of the skin and for  
"which there is no known cure. The  
"company has been busy every time it  
"makes a sale of this product. Still  
"another company produces a derivative  
"called 2 FU. (unclassified)  
"in the treatment of certain cancers,  
"it is given free to qualified  
"patients.  
"Regarding a pamphlet there, there is:  
"A product known as Lofenal is  
"truly a life-saving drug to suffering  
"of phenylketonuria. This is a rare  
"disease of children which, if untreated,  
"will eventually cause permanent and  
"fatal damage to the brain. (unclassified)  
"This disease can be easily detected  
"and, if detected in the early stage,  
"the brain damage can be prevented by  
"the use of this product, permitting  
"the child and later on adult to  
"have a normal life. This is the  
"only product of its kind available in  
"Canada, yet the company asked if  
"available at all, asking no price  
"in return for the product."



Conder

10607

THE CHAIRMAN: We were told a drug acquired in this connection for four or five years, which would be necessary, cost several thousand dollars. \$4 to \$6 thousand dollars. The treatment.

MR. CONDER: The treatment; I have heard that figure, yes, and we must remember that the treatment is not in the drug alone.

This also includes the medical care and the physician services and nursing care and many other factors.

THE CHAIRMAN: I must say, while this figure was being given, it was being given as compared with the \$80 or \$90 thousand dollars it would cost for custodial care of the child if this drug treatment was not given.

MR. CONDER: That is true.

THE CHAIRMAN: It was not given in terms of criticizing the cost of that treatment. You start at the foot of page 100, all through page 101 and deal with the sale of pharmaceutical products and so forth; use of advertising distribution, samples and use of detailmen. "Detailmen" having a special meaning in this connection.

Again, the suggestion is made that these three items constitute a very heavy load part of the price on which drugs are sold by the manufacturing companies to the retail trade and that some is an unnecessary expense.

Now, in the figures which you were good enough to give us, in general totals it would appear,





1952. 1951.

THE CHAIRMAN: We were told a drug

applied in this connection for four or five years,  
which would be necessary, cost several thousand dollars.  
\$4 to \$5 thousand dollars. The treatment.

MR. CONNEL: The treatment; I have

heard that figure, yes, and we must remember that the  
treatment is not in the drug alone.

This also includes the medical care

and the physician services and nursing care and many  
other factors.

THE CHAIRMAN: I must say, while this

figure was being given, it was being given as compared  
with the \$50 or \$60 thousand dollars it would cost for  
custodial care of the child if this drug treatment  
was not given.

MR. CONNEL: That is true.

THE CHAIRMAN: It was not given in

terms of evaluating the cost of that treatment. You  
start at the foot of page 100, all through page 101 and  
deal with the sale of pharmaceutical products and so  
forth; use of advertising distribution, salaries and  
use of detailmen. "Detailmen" having a special meaning  
in this connection.

Again, the suggestion is made that

these three items constitute a very heavy load  
part of the price on which drugs are sold by the  
manufacturing companies to the retail trade and that  
there is an unnecessary expense.

Now, in the figures which you were given  
enough to give us, in general terms it would appear,



Conder

10608

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2  
3 in round figures, direct mail advertising by the  
4 companies mentioned was about \$3 million a year.  
5 Samples, in round figures, \$4 million. The detailmen  
6 expenses, \$9,700,000. So that we are now working on a  
7 basis of about \$100 million. \$180 million. Of course,  
8 that includes the non-prescription drugs.

9 MR. CONDER: Did you say \$180 million,  
10 sir?

11 THE CHAIRMAN: Yes.

12 MR. CONDER: These figures are based  
13 on human pharmaceutical sales of roughly \$108 million.  
14 This is a survey by a group of companies.

15 THE CHAIRMAN: We have, in round  
16 figures, approximately \$16 to \$17 million. In these  
17 items we have 16 - 17% of the total manufacturing dollar  
18 that the manufacturer takes in from the trade, from  
19 all sources.

20 Now, do you want to comment on that?  
21 Is this out of line with other manufacturing industries?

22 MR. CONDER: We do not believe that it  
23 is too far out of line with other manufacturing indus-  
24 tries, although we have not seen specific figures  
25 given for Canada in this area.

26 THE CHAIRMAN: Dr. Firestone has just  
27 drawn to my attention an item on page 6 that there is  
28 an extra selling cost of \$12,552,000 to add to that.  
29 So that we have now pretty close to \$30 million of the  
30 total take.

31 In round figures, 30% of the dollar  
32 going in sales cost in one form or another.



in round figures, direct mail advertising by the  
companies mentioned was about \$3 million a year.  
Parties, in round figures, \$4 million. The detailed  
expenses, \$2,700,000. So that we are now working on a  
basis of about \$100 million. \$180 million. Of course,

MR. COLLIER: These figures are based  
on human pharmaceutical sales of roughly \$100 million.  
This is a survey by a group of companies.

THE CHAIRMAN: We have, in round  
figures, approximately \$16 to \$17 million. In these  
items we have 10 - 15% of the total manufacturing dollar  
that the manufacturer takes in from the trade, from  
all sources

Now, do you want to comment on that?  
Is this out of line with other manufacturing industries?  
MR. COLLIER: We do not believe that it  
is too far out of line with other manufacturing indus-  
tries, although we have not seen specific figures  
given for Canada in this area.

THE CHAIRMAN: Mr. Fineston has just  
drawn to my attention an item on page 6 that there is  
an extra selling cost of \$12,500,000 to add to that.  
So that we have now given close to \$30 million of the  
total take.

In round figures, 30% of the selling  
going in sales cost in one form or another.





Conder

10609

MR. CONDER: Actually, when it comes down to the matter of medical promotion and detailing, it works out to about 17% for medical promotion and detailing. The balance of about some, roughly, 10% would be based on selling factors which are not directly connected with medical promotion and detailing of doctors, and these are factors which are important to keeping representatives from coast to coast in Canada.

Whether these detailmen are detailing doctors or not, sir, the companies would still be required to maintain field representation from coast to coast.

THE CHAIRMAN: But you have the field representation in this \$12 million-odd. \$6,882,000 expense for sales representatives.

MR. CONDER: That is right.

THE CHAIRMAN: \$1,700,000 and then other selling expenses, \$6,882,000. Sales representatives, \$3,735,000 and donations, \$192,000. You come up with a figure of \$12,552,000 in these additional selling expenses on top of the medical promotion and detailing of doctors.

I am not opening any discussion on this item F, which is the \$12 million because, as you say, you have to maintain a sales organization, but the criticism that has come to us is that the drug industry spends too much of the drug purchaser's dollar in this medical promotion, and so forth.

MR. CONDER: Mr. Chairman, I would submit





100

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MR. CONNER: Actually, when it comes

down to the matter of medical promotion and detailing, it works out to about 75¢ for medical promotion and detailing. The balance of about 25¢, roughly, 15¢ would be based on selling factors which are not directly connected with medical promotion and detailing of doctors, and these are factors which are important to keeping representatives from coast to coast.

Whether these gentlemen are detailing

doctors or not, sir, the companies would still be required to maintain field representation from coast to coast.

THE CHAIRMAN: But you have the 15¢

representation in this \$12 million-one. \$6,882,000 expense for sales representatives.

MR. CONNER: That is right.

THE CHAIRMAN: \$1,700,000 and then

other selling expenses, \$6,332,000. Sales representatives, \$3,735,000 and donations, \$192,000. You come up with a figure of \$11,922,000 for these additional selling expenses on top of the medical promotion and detailing of doctors.

I am not opening any discussion on this

item, which is the \$12 million because, as you say,

you have to maintain a sales organization, but the criticism that has come to us is that the drug industry spends too much of the taxpayer's dollar in this medical promotion, and so forth.

MR. CONNER: Mr. Chairman, I would submit



Conder

10610

that as we mentioned in the summary earlier, that our companies do not spend money unnecessarily.

They have found, through experience over the years, that this is an essential part of doing business in this industry. If some method could be found which would effectively accomplish the same result with the industry to maintain an effective merchandising and marketing of pharmaceuticals from coast to coast, without these factors, I am sure many of our companies would be interested in them.

Some companies, from time to time, have tried this. I recall Mr. Leslie of Ayerst, McKenna and Harrison Limited in a submission to the Restrictive Trade Practices Commission - I am sorry, the Ontario Government Select Committee on Drugs - and he was asked whether they had, at any time, cut back on direct mail advertising and he said that they had in one particular instance decided to do away with it and when asked the result of it, he said they definitely lost money and sales did drop as a result of this.

THE CHAIRMAN: That is because the others did not. One vendor has to keep up with the others. That is really what he said, wasn't it? He couldn't do it by himself.

MR. CONDER: If you have a product that is sitting in your retail store your medical practitioner will not prescribe it if he has not been informed about it.

COMMISSIONER BALTZAN: Do your detail-men only confine themselves to visiting and informing



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couldn't do it by himself.

THE CHAIRMAN: It was a product

that is sitting in your retail store your medical

prescriptions will not prescribe if he has not been

informed about it.

THE CHAIRMAN: Do you recall -

men only continue themselves to visiting and informing





Conder

10611

physicians, or do they not also visit and inform the drugstores?

MR. CONDER: Yes sir, they do. They visit drugstores. They try and keep the pharmacists in the drugstores informed of the latest developments in their own particular field.

They assist, in some cases, in assisting the pharmacist to maintain a stock and watch control of the stock, particularly on dated merchandise.

They also service hospitals, pharmacies in hospitals and in some cases the staffs of the hospitals and they will occasionally, depending on the company, and the type of operation, serve as a go-between between clinical investigators and the medical directors of our companies.

Not that the detailmen are experts in this field, by any means, but merely provide merchandising information, passing on information which the medical directors of the companies may wish to provide.

COMMISSIONER BALTZAN: All of this comes under this one item we are talking about?

MR. CONDER: All of this comes under the cost of detailmen.

THE CHAIRMAN: Now, Mr. Conder, I just want to follow that a little way. In the information which you gave us you said that the companies reported - this doesn't take in all the companies in Canada - you say 7 firms employed so-and-so, you come up with a figure of 1,647 detailmen.

MR. CONDER: I believe, sir, the



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MR. CHAIRMAN: All of this

comes under this one item we are talking about?

MR. CHAIRMAN: All of this comes under

the cost of distribution.

MR. CHAIRMAN: Now, Mr. Conner, I just

want to follow that a little way. In the information

which you gave us you said that the companies reported -

this doesn't take in all the companies in Canada - you

say 7 firms employed so-and-so, you come up with a

figure of 1,647 detailmen.

MR. CHAIRMAN: I believe, sir, that



Conder

10612

figure was approximately 1,500.

THE CHAIRMAN: I am just reading, based on these factors, and it is estimated that of the total of 1,647 men, approximately 1,500 spend all or part of their time calling on medical practitioners. I was going to read the whole sentence.

Then you go on, on the next page, that there are, of the 21,000 doctors in Canada, 17,900 may be regarded as medical practitioners with whom the industry makes contact.

MR. CONDER: Yes.

THE CHAIRMAN: So that broken down you have one detailman for every 12 doctors practising medicine in Canada.

MR. CONDER: That might seem unusual in ---

THE CHAIRMAN: I am told the figure in the United States is one in ten. We are a little ---

COMMISSIONER McCUTCHEON: Behind the States.

THE CHAIRMAN: --- more conservative.

MR. CONDER: I might add, sir, for your consideration, that some of these medical practitioners are spread far and wide across our country and it is contingent upon the company to ensure that all medical practitioners are kept informed of the developments of their products.

Particularly out in the Western Provinces a detailman might have to travel great distances to see but only one doctor.



Condor

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THE CHAIRMAN: I am just reading,

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Then you go on, on the next page, that

there are, of the 21,000 doctors in Canada, 17,800 may be regarded as medical practitioners with whom the industry makes contact.

MR. CONDOR: Yes.

THE CHAIRMAN: So that broken down you

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but only one doctor.





Conder

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THE CHAIRMAN: I think you can assume Dr. Baltzan and I have a fairly good idea of how far you have to go all through Western Canada and I would not accept that too completely, Mr. Conder. The medical profession are pretty well bunched in the Prairie province areas.

We have read, in individual submissions, that this is necessary. In addition to this 1,500 you have also got the sales representatives that cost you \$5,400,000.

MR. CONDER: No, sir. That is all included in the 1,500; percentage of the time that the average detailman spends in promoting or working.

THE CHAIRMAN: Now, does the figure on page 6 - have you got it before you?

MR. CONDER: Yes, I have.





Conder

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THE CHAIRMAN: Now, does the figure on

page 6 - have you got it before you?

MR. CONDER: Yes, I have.



/hm

10614

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4 THE CHAIRMAN: Would that \$3,700,000.  
include detailmen?

5 MR. CONDER: That would be the  
6 percentage of the time of the detailman that is spent  
7 in other than medical promotion.

8 COMMISSIONER McCUTCHEON: In other  
9 words you have tried to pro-rate your total sales  
10 expenditures between the time spent on medical promotion  
and detailing and other promotion?

11 MR. CONDER: That is correct, yes.

12 THE CHAIRMAN: I didn't read it this  
13 way, but maybe an accountant might. E, review of  
14 medical promotion and detailing costs -- the \$12 million  
15 in F is part of the \$9 million.

16 MR. CONDER: Oh no, sir, actually in  
17 undertaking a survey of our industry Clarkson, Gordon  
18 and Company found that approximately 40 to 50% of the  
19 time of detailmen working for most companies was spent  
20 in work other than medical promotion or detailing  
doctors.

21 COMMISSIONER McCUTCHEON: What was  
22 the percentage, I am sorry.

23 MR. CONDER: It ran from 40 to 50%.  
24 There were about five companies whose men spent all  
25 their time only in working with doctors, so that brought  
26 it to a mean average, I think, of 36% as the result  
of that time.

27 THE CHAIRMAN: This is in addition  
28 to the direct mail advertising that goes to the 17,900  
29 doctors?  
30



THE CHAIRMAN: Would that \$2,700,000.

includes detailing?

MR. CONNER: That would be the

percentage of the time of the detailman that is spent

words you have tried to pro-rate your total sales

expenditures between the time spent on medical promotion

and detailing and other promotions?

MR. CONNER: That is correct, yes.

THE CHAIRMAN: I didn't read it this

way, but maybe an accountant might. E, review of

medical promotion and detailing costs -- the \$12 million

in 7 is part of the \$2 million.

MR. CONNER: Oh no, sir, actually in

undertaking a survey of our industry Clarkson, Gordon

and Company found that approximately 40 to 50% of the

time of detailmen working for most companies was spent

in work other than medical promotion or detailing

COMMISSIONER McCUTCHEON: What was

the percentage, I am sorry.

MR. CONNER: It ran from 40 to 50%.

There were about five companies whose men spent all

their time only in working with doctors, so that brought

it to a mean average, I think, of 32% as the result

of that time.

THE CHAIRMAN: This is in addition

to the direct mail advertising that goes to the 17,000

doctors?





Conder

10615

MR. CONDER: Yes sir.

THE CHAIRMAN: Is it the industry's statement that the doctors cannot be informed by mail and they have to be personally instructed?

MR. CONDER: We have found, sir, in surveys that the sources of new information on new products received by doctors, approximately something like 69% of it was obtained through detailmen and approximately 18% of it was obtained through direct mail.

THE CHAIRMAN: Do you not duplicate, do you send him information as well as the detailmen?

MR. CONDER: Yes.

THE CHAIRMAN: You are saying the doctor doesn't read it?

MR. CONDER: He may not in some cases. In some cases he may.

THE CHAIRMAN: Is that because he doesn't want to take the double time he must put in with the detailman and to read?

MR. CONDER: No sir, like everyone else doctors have their particular preferences in methods of operating. If we say all doctors are 100% in favour of detailmen it would be no more correct than attempting to say all doctors are 100% in favour of direct mail. Some doctors will read direct mail, check it through. We know as a fact some like to receive direct mail. Those very doctors may not wish to see the detailman and may instruct their nurses accordingly. Another person might prefer to get information from the detailman and not take time reading through mail.





Yes sir.

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Conder

10616

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4 THE CHAIRMAN: We are concerned with  
5 this matter, and not only from the standpoint of the  
6 druggist, but as the efficient utilization of the medical  
7 man.

8 MR. CONDER: Yes.

9 COMMISSIONER BALTZAN: All these things  
10 are purely business methods, this matter of written  
11 publications all contribute to the promotion of your  
12 business?

13 MR. CONDER: Yes sir, it certainly  
14 does.

15 THE CHAIRMAN: The same way as the  
16 cigarette manufacturers on the radio. They wouldn't  
17 spend the money if they weren't going to get it back.

18 MR. CONDER: No.

19 COMMISSIONER BALTZAN: There is another  
20 question that should not be put to you directly, but  
21 to the medical people: How much value and how much  
22 contribution will you be making by dispensing a lot  
23 of the material one way or the other, by direct  
24 representation or by mail or even in the medical journals.  
25 We have done so. I am not going to quote directly. My  
26 memory is not good enough, but there is a contrary  
27 opinion. The majority of the opinion is to the effect  
28 that the service you are rendering is scientifically  
29 and medically really valuable, for promoting the  
30 scientific aspects of the utilizations of these very  
good products that you are distributing. It just  
doesn't seem to balance out, when you think in terms  
of \$12 million which is good for the industry, whether



10516

Order

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of \$12 million which is good for the industry, whether





Conder

10617

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3 that \$12 million is good for the doctors who prescribe  
4 and the people who have to pay that extra \$12 million.  
5 I think that is a serious challenging problem.

6 MR. CONDER: Yes sir. We have found  
7 that there are doctors that dislike the practice of  
8 the detailman calling him. We have found doctors that  
9 dislike the practice of direct mail coming to them and  
10 say it adds to their cost, but by the same token we  
11 have found a great number of doctors that do find that  
12 the services of the detailmen, and I am speaking of  
13 good detailmen now.....

14 COMMISSIONER BALTZAN: I am not speaking  
15 critically. I am trying to be realistic.

16 MR. CONDER: I can appreciate that,  
17 sir.

18 THE CHAIRMAN: When you speak of  
19 good detailmen, in general they are graduate pharmacists?

20 MR. CONDER: Graduate pharmacists or  
21 they may be someone who has pre-med education and may  
22 not have completed his medical education for some reason.

23 THE CHAIRMAN: The majority are, as  
24 I understand, graduate pharmacists?

25 MR. CONDER: Yes sir. The majority  
26 have university training.

27 THE CHAIRMAN: In pharmacy?

28 MR. CONDER: No, I wouldn't say the  
29 majority do have pharmacy.

30 THE CHAIRMAN: If that is not so I will  
accept it.

MR. CONDER: Approximately one-half.





that 212 million is what the doctors who prescribe  
and the people who have to pay that extra 212 million.

MR. CHAIRMAN: Yes sir, we have found

that there are doctors that do the practice of  
the decision only in part. We have found doctors that  
do the practice of the most and come to their  
own mind to their cost, and in the same token we  
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MR. CHAIRMAN: That is not as I still

MR. CHAIRMAN: Approximately 50-50.



CONDER

10618

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4 THE CHAIRMAN: And therefore we have  
5 to face the question whether that is the proper utiliza-  
6 tion. There are great demands for the extension of  
7 pharmacy facilities, for the training of pharmacists  
8 at the university level -- they want scholarships, they  
9 want everything, to train salesmen for the pharmaceutical  
10 companies. The problem of utilization of the university  
product is involved.

11 MR. CONDER: I believe, sir, that many  
12 of our companies would agree they would like to have  
13 pharmaceutically trained personnel for their detail  
14 staff because of the fact it is essentially part of their  
15 business in calling on doctors to have a complete and as  
16 thorough a background as possible in the field of  
17 pharmacy. They have to know it also to have a better  
18 appreciation of their own products and to answer  
19 questions which the doctor might put to them. Many of  
20 our companies would like to have all their detailmen  
21 as pharmacists. It is not practical in all cases, of  
22 course, even if the pharmacists were available for this  
23 purpose, which they are not.

24 THE CHAIRMAN: In this matter of  
25 prescribing by generic names, I accept your viewpoint  
26 that you don't think it is either practical or desirable  
or so forth, but you know there is legislation in the  
Province of Alberta?

27 MR. CONDER: That is correct.

28 THE CHAIRMAN: Which enables the  
29 pharmaceutical chemist in dispensing a prescription to  
30 use a drug that is a generic or equivalent of that named

THE CHAIRMAN: And therefore we have

to face the question whether that is the proper utilization. There are great demands for the extension of pharmacy facilities, for the training of pharmacists at the university level -- they want scholarships, they want everything, to train salaried for the pharmaceutical companies. The problem of utilization of the university product is involved.

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Conder

10619

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4 in the prescription unless the prescriber indicates  
5 otherwise by specifying the trade name or by specifying  
6 no equivalent is to be dispensed. That was proclaimed,  
7 I understand, on the 5th of April.

8 MR. CONDER: It was enacted on the 5th.

9 THE CHAIRMAN: No, proclaimed. Perhaps  
10 you might verify that, Mr. Frawley.

11 MR. FRAWLEY: The date it was assented  
12 to was the 5th of April, 1962.

13 THE CHAIRMAN: It came into force  
14 on the day it was assented to?

15 MR. FRAWLEY: That is correct, sir.

16 THE CHAIRMAN: Have you had any  
17 experience yet of the working out of that legislation?

18 MR. CONDER: We have found to date  
19 that it has not made a measurable difference in the  
20 prescribing habits or the dispensing habits of the  
21 physicians or pharmacists in that province. We as an  
22 industry and as an association are opposed to this type  
23 of legislation on the grounds it is not in the best  
24 public interest. We made a rather lengthy submission  
25 in letter form to the Minister of Health just prior to  
26 the third reading of the bill and pointed out our views  
27 to the Minister at that time.

28 THE CHAIRMAN: Has the industry taken  
29 any steps to neutralize the effect of the bill or the  
30 act?

MR. CONDER: The industry as such has  
taken no direct steps at this stage to attempt to  
neutralize it.





Order

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Conder

10620

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4 THE CHAIRMAN: We have been informed  
5 they have -- the physician generally is given a prescrip-  
6 tion pad by the drug store or something of that kind  
7 and they have now been printed with the exception  
8 being printed right on the pad that there is to be no  
substitution.

9 MR. CONDER: I was finishing my  
10 statement, sir. The industry as such, by that I mean  
11 our Association has not taken a step in this area as  
12 yet. I believe that the issuing of prescription pads  
13 pre-printed with no substitution has been done by one  
14 company, and to the best of my knowledge only one  
15 company to date has made that available throughout the  
province.

16 COMMISSIONER McCUTCHEON: That company  
17 is doing that to save the doctor time so he won't have  
18 to write that in. It is better utilization of the  
19 physician?

20 THE CHAIRMAN: And continuing education  
21 of the physican.

22 MR. CONDER: I might add, sir, it  
23 has been mentioned before this Commission that part of  
24 the job of the detailman in the company is to educate  
25 the physician. I would like to correct this misconception.  
26 It is not our job to attempt to educate the physician  
27 in any form whatsoever nor do we ever do that. I  
28 believe the physicians are well informed and well  
29 educated in medicine. Our sole job is to keep the  
30 physician informed of the products which he may add  
or may not add to his armamentarium if he so desires.



Q. Now, sir, have you been informed

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physician in touch of the progress which he may add

on any day to his experimentation if he so desires.





Conder

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COMMISSIONER BALTZAN: Could you tell us who produces the Vademacum?

MR. CONDER: It is produced by J. Morgan Jones Publications.

COMMISSIONER BALTZAN: You then participate in this publication, the pharmaceutical companies of Canada?

MR. CONDER: Yes sir, it is a service which Morgan Jones Publications makes available to the pharmaceutical companies at so much per page. The companies which have their product named in there prescribe.

COMMISSIONER BALTZAN: In other words you are sponsoring that?

MR. CONDER: Pardon?

COMMISSIONER BALTZAN: You are sponsoring, you are participating in that service?

MR. CONDER: Not this association, the individual companies are, but not all of our companies are in that publication.

COMMISSIONER BALTZAN: It is proving a very valuable thing. I am going to ask whether it could be as a means for reducing this amount we are talking about by having that issued not in a whole as it is now being done annually, but perhaps in addition or supplement something comparable to the Medical Newsletter -- either once a week or once a month.

MR. CONDER: That would be equivalent to the Prescribers Journal which was started in the United Kingdom. I believe it has not proved overly







Conder

10622

effective.

COMMISSIONER BALTZAN: That could always be distributed as this is being distributed and it has valuable up to date information.

MR. CONDER: If you would be interested I have an editorial which appeared in the Canadian Medical Association Journal on July 1st, 1961 entitled "Prescribers Journal," which gives at least one opinion on this, if you would care to have it.

COMMISSIONER BALTZAN: I would be glad to read it later, but I don't think it is important. What was the date?

MR. CONDER: July 1st, 1961, Canadian Medical Association Journal on page 40 entitled "Prescribers Journal".

COMMISSIONER BALTZAN: What is the particular agency or service? It is not the Medical Newsletter -- what does it refer to?

MR. CONDER: Prescribers Journal.

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COMMUNIST PARTY BALTIMORE: What is the

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News letter -- what does it refer to?



Conder 10623

MR. CONDER: This was a publication which was attempted in the United Kingdom much along the lines of the one you were suggesting a few minutes ago.

COMMISSIONER FIRESTONE: Mr. Conder, may I refer to Page 100, the fourth paragraph. You say, and I quote: "Patents do not have a major bearing on drug prices and because of the competitive factor no company can inflate prices beyond reason regardless of whether the drug is patented or not". Could you explain to us how the competitive factor works in the case of drugs that are patented?

MR. CONDER: The competitive factor works much the same as in drugs that are not patented. When a company introduces a product onto the market it must determine whether it can keep its production costs and its overall manufacturing costs in line with other products which may be in the same therapeutic class. If it increases that price of its product because of patents, or any other factor, above, and I say this to any measurable degree above the prices of the other products in the same therapeutic class, it probably will not sell.

COMMISSIONER FIRESTONE: But if there are new discoveries, and the results are patented, and there is no comparable product on the market, yet one product is first and others follow, it is a gradual process, how is the price kept down on that particular product, if it is patented?

MR. CONDER: You are envisaging here a product which would be brand-new, that it would have no





10823 Conder

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MR. CONDER: You are envisaging here a

product which would be brand-new, that it would have no



Conder 10624

direct competitor in the same therapeutic class?

COMMISSIONER FIRESTONE: Exactly, sir.

THE CHAIRMAN: No immediate competitor.

COMMISSIONER FIRESTONE: Yes, and in the process of progress, over the time the competition will catch up, but there is a time element, and one company comes out with a new product and patents it. Now, what is to prevent that company to charge a fairly high price? They are the first on the market.

MR. CONDER: You would have to look at it from this viewpoint as well, that prior to the introduction of this product the medical profession were probably using other products for the same treatments. If this were such a revolutionary product that it exceeded everything else in the field, then it would have an exclusive use on the market. It would probably last a year or two at the very, very outside.

The company may decide to place its price according to what the traffic will bear. Again it may decide to keep its price down in order to make it more appealing to the doctors or to the general market.

It has been stated that because of our compulsory licensing provision that the average Canadian manufacturer who introduces a new product on the market must recoup his losses, his cost factors, within the first year, or he will probably lose his shirt on the product, but by that same token that manufacturer must also put his price based on whatever the other competing products are in the same therapeutic class.

COMMISSIONER FIRESTONE: Well, I take



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COMMISSIONER FIRSTONE: Exactly, sir.

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COMMISSIONER FIRSTONE: Well, I take





Conder 10625

it from what you say that in the initial period the competitive factor does not work, until the competitors have caught up with a similar product?

MR. CONDER: If it is something ultra-revolutionary, yes, but very few products nowadays don't have some competing product in the same therapeutic class.

COMMISSIONER FIRESTONE: It may be in the same therapeutic class, but it may be somewhat better than the existing products, and I presume that the company producing the better drug will say so, and try to convince the doctors, through their detail-men. So in that sense of producing a better mousetrap enables the company to do more sales by producing a better drug in this particular class.

MR. CONDER: And experience shows that competitors come along very fast, even too fast for some companies.

COMMISSIONER FIRESTONE: May I now turn to the next paragraph, on Page 100, the last paragraph on that page: "An efficient information service is vital to the health of the nation". When you speak of an efficient information service in this context, I take it you refer to the information we have supplied by the drug manufacturers of Canada, or in Canada, or drug suppliers in Canada?

MR. CONDER: Yes, that is correct. We say that an efficient information service is vital to the health of the nation. This is the information which may be presented for consideration of the doctor by a detail-man, by direct mail, through a medical journal,





10115 Conder

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Conder 10626

in which case it may be an article, for example, submitted by some clinician to that journal.

COMMISSIONER FIRESTONE: I am just wondering how efficient this information service would be if most of it is done through the detail-man, or direct mailing, if this information is passed on by people, in the case of detail-men, who represent the interests of a particular company it would be only natural for them to extol the virtues and products of their company?

MR. CONDER: Yes.

COMMISSIONER FIRESTONE: Would you feel then, that the service that is being provided at the present time is really an objective service, or is it a service that is designed to provide information of the highest quality and the virtues of the product of each individual company?

MR. CONDER: I believe it is, sir, because there is no one but a person who specializes in a single product that knows more about that product. A person that is dealing with a number of products from a company becomes quite familiar with these products, and is in a very fortunate position to be able to answer questions which may be presented to him about those products.

COMMISSIONER FIRESTONE: Well, I am just wondering whether the detail-man would be inclined to answer questions of products of equivalent value or quality, or potency, produced by other companies. His job is to sell the products of the company he represents,

in which case it may be an article, for example, submitted by some of the other members of the committee.

COMMISSIONER TILGNER: I am just

wondering how efficient the information service would be if it is done through the detail-men, or if, at least, if this information is passed on by people, in the case of detail-men, who represent the interests of a particular company it would be only natural for them to extol the virtues and products of their com-

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Conder 10627

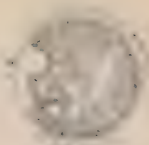
and therefore would you not say that this service is tailor-made to the sales requirement of the manufacturers or distributors, rather than tailor-made to giving the profession an overall point of view on particular drugs?

MR. CONDER: What would the alternative be, Dr. Firestone? Would it be someone who could for example, speak of 150 different products, all competing in various therapeutic classifications, someone who could be so effective, and know so thoroughly all the side effects which affect equivalency, so-called equivalency between different products?

COMMISSIONER FIRESTONE: Would you say, sir, that there would perhaps be the possibility to have an information service that would be either medically-sponsored or government-sponsored, that would provide doctors with that sort of information which they seek on an objective basis, and would you not perhaps feel that that might achieve the objective which you state in this paragraph, and which is a very desirable one I may say. That we should have in Canada an efficient information service, but I am looking for an information service that is objective, and that does not, without suggesting anything being improper, bring in conflicts between the self-interest of the company and the need for providing the physicians with the most adequate and objective information available on the subject?

MR. CONDER: I doubt whether any single source could do a comprehensive and effective job of ensuring that every doctor in Canada is kept informed, and kept up to date on every product that is turned out of





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Canada. The job would be a phenomenal one, because in many cases it takes a company and all the resources of a company, particularly in a new product, to be able to bring this product to the attention, effectively to the attention of the medical profession, and it does not mean that you send a notice to a doctor today that such and such a new product has been developed. He may take a look at it and decide to keep using the products he has been using, and ignore this. Next year, a year later, he may come around to trying this product and devoting a little more study to it.

We believe the best person to know the so-called equivalency of medication is the medical practitioner himself, and I would venture that in the majority of cases the doctor does not prescribe a product merely on the say-so of the manufacturer, particularly a new medication. He will study this new product, test and evaluate it himself.

I believe it was mentioned a couple of days ago before this Commission on this basis of equivalency, some doctors didn't believe in the philosophy of equivalency, but in the philosophy of testing and using drugs, based on their own knowledge, and I believe this is the most important factor of all, sir.

COMMISSIONER FIRESTONE: If I understand the implication of your question, Mr. Conder, and please correct me if I misunderstand you, it is based on the assumption that such an information service would replace the detail-man, but that was not my question.

My question is that if the medical



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COMMISSIONER WINSTON: If I understand the implication of your question, Mr. Gordon, and please correct me if I misunderstand you, it is based on the assumption that such an information service would replace the dealer-man, but that was not my question. My question is to see if the new





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profession wishes to obtain an objective information service, or advice, on the conflicting stories they may hear from different detail-men, could they not go to an organization, which is a non-profit, either medically-sponsored or government-sponsored, and say: "Now, here is the problem I face. What is the story on this, or what is the story on that?" Obviously the doctor would make his own decision, but he would have an organization to turn to, rather than a salesman who is interested in selling the product of the company, even though that salesman may be very well-qualified, a pharmacist, et-cetera.

COMMISSIONER BALTZAN: Would it help you in thinking about rather than an organization, but you are thinking in terms of an information centre? Could there be a built-in section in the Department of Pharmacology of a medical school?

COMMISSIONER FIRESTONE: I didn't want to get involved in the details of how such a centre would be organized. I am solely concerned with the principle, as to whether your industry would support the principle of such a centre?

MR. CONDER: I can see no harm from our viewpoint, but I doubt if it could be effective. For one reason, there have been produced, I would say during the year 1961, about fifty entirely new chemical entities in the field of medication. These are drugs which have not been known before, brand-new chemical substances. There have been several hundred new compound preparations. Companies which bring these preparations out may be able





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to devote all their resources and facilities to studying one of these preparations. They have conceivably medical directors, and directors of research, and other people working on the correlation and distribution of information on this. If you have several hundred products coming out every year on this basis, and these are valuable products insofar as they contribute to medical progress, it would seem rather difficult from my viewpoint that one source, even a department of a university, would have enough people available that could effectively study and correlate all the details in all the new products.

If you have two competing products in this area, and one company makes certain claims for its product and the other company makes certain claims for its products, it would be contingent on this body to take these products, study and evaluate them, and go through all the clinical trials, studies and evaluations required, in order to insure that these products do the job involved.



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Conder

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MR. CONDER: Now, some of these products might have been under study for 8 or 9 years. I can think of a product turned out by one of our companies not too long ago which was a result of 5 years' study and the result of 11,000 clinical trials.

It would be a very demanding job for anyone, sir, other than giving a superficial viewpoint. Not even a doctor who would be receiving this material could give more than such a superficial consideration to the product he will be using.

COMMISSIONER FIRESTONE: The more you are talking about it, the more you convince me of the necessity for such a centre because you point out a large number of these new drugs come on the market in a bewildering array of drugs and claims made for those drugs.

Doctors are busy people. How can they, in trying to look after a practice appraise this themselves unless they take the word of the detailmen?

I think you have expressed your views and I accept them as such. My other question is in this connection: if such a centre were established and the sponsoring agency came to the drug manufacturing industry and asked for their co-operation and participation, what would you think would be the answer?

MR. CONDER: From the viewpoint of our Association I believe it would be quite prepared to co-operate with you to the fullest extent.

From the viewpoint of individual companies, it may be another matter because individual





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companies are very jealous of new products until those products are placed on the market and it may be difficult, in some areas, to get co-operation of companies until such products have been marketed.

Aside from that, I would imagine they would be prepared to co-operate.

COMMISSIONER FIRESTONE: Presumably such a centre would deal with items after they come on the market. Nobody would want to go to the secrecy of companies' operations. Thank you very much.

Now, may I turn to the second paragraph, page 101, where you make a statement, that

"Selling prices of drugs at the manufacturers' level are most reasonable, and retail prices are within the means of the average Canadian's purchasing ability."

What evidence do you have for that statement?

MR. CONDER: We would submit the evidence for this statement based on the comparison of the consumer price index for prescriptions which has risen 2.3 since 1949 compared to the average rate in manufacturing which has been some 81.3 over that period.

COMMISSIONER FIRESTONE: That relates to price increases. Does it really relate to the phrase which you have here: "...within the means of the average Canadian's purchasing ability."?

MR. CONDER: Yes, sir, we believe that.



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Conder

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Although I realize that these figures are dated now, the Survey on Family Expenditures in 1953 shows something like .74. A rather low amount compared to other expenditures on luxury items and expenditures for housing and food and other factors.

The ratio is quite small in proportion to the total.

COMMISSIONER FIRESTONE: Well now, sir, you make that reference in the next sentence in the same paragraph. The comparison between family expenditures for prescription drugs are relatively minor in comparison to expenditures for luxury and non-essential items.

I wonder how appropriate such a comparison is, bearing in mind people cannot defer expenditures on prescription drugs when they are ill because they require the drugs. They can defer luxury items.

MR. CONDER: That is true, sir. By virtue of the total amount spent by the family over a period of years, it would put us into the position of assuming, by virtue of these amounts spent, they can afford to set aside the amounts required for medication.

We are speaking here of the average family, sir, and not the indigent, economic indigent, medical indigent, whichever you will, or others who may be affected through long-term usage.

COMMISSIONER FIRESTONE: If that is your view, sir, how do you explain the complaints that we have heard from one end of the country to the other?





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Conder

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People find it hard, in many instances - and these are not just indigent people. People in the middle income bracket find it hard to pay for drugs which they find are rather high-priced.

Is there a difference of opinion?

Perhaps the public does not understand the family income expenditure survey which you have been quoting to us? What is the reason?

MR. CONDER: By the same token that you would question our statement, sir, that the cost for prices of consumer drugs are most reasonable, we would also question the statements which have been made by others before this Commission to the effect that prices are high.

We have attempted to document here that prices are not unusual.

COMMISSIONER FIRESTONE: By "unusual" you mean unusually high?

MR. CONDER: Yes. Out of line.

COMMISSIONER FIRESTONE: Out of line with what, sir?

MR. CONDER: Out of line with the general purchasing ability of the individual.

COMMISSIONER FIRESTONE: In other words, if I understand you correctly, you feel this complaint about drug prices being high, and beyond the means of many families, is not justified in the light of the facts as you have them?

MR. CONDER: Yes, sir.

COMMISSIONER FIRESTONE: And as you



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MR. CONNOR: Yes, sir.

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Conder

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interpret them?

MR. CONDER: That is right.

COMMISSIONER FIRESTONE: Now, if I may turn to paragraph 4 on page 101, in which you say, and I quote:

"If a problem does exist in this area, then it is with a small percentage of the population which, for reasons of sub-standard income or chronic illness, finds it difficult to purchase all commodities and services including drugs."

This paragraph suggests that there is a problem with a number of families?

MR. CONDER: Yes, sir. Mind you, this is an opinion. We don't know how far this extends. We do know it exists and most definitely recognize it.

COMMISSIONER FIRESTONE: Well now, sir, perhaps the industry may have no views about it. If so, please say so. If your Association has some views, please say so. How can we develop a system that would take care of the problems of these families that, for reasons of sub-standard income or chronic illness, find it difficult to pay for the drugs which are prescribed which they require?

MR. CONDER: We have looked into this at some length, Dr. Firestone, to the extent even, in one case, of retaining an economist to determine the practicality of our embarking on a socio-economic study of the field of drugs and the needs which exist.





MR. CONNOR: That is right.

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We were advised not to attempt to undertake it ourselves because it would be too comprehensive a program. It should be undertaken by possibly some government organization as a result of our recommendation; that the Commission might wish to consider this point.

We feel that before a decision can be made as to how we go about this, we should find out exactly what does exist and the degree of this indigency part of it.

You are using the term "medical indigent". In our brief we are referring to them as economic indigents. It's the same thing. How prevalent is this economic indigency? What are the degrees required to provide a patient with pharmaceuticals discharged from any hospital and all these various factors.

We believe that this whole subject should first be subjected to very careful scrutiny and study and then we find out the exact area of the problem involved and then a definite answer and we would be most willing and most prepared to assist any government body, be it a section of the Commission or any agency you may wish, to help such a group undertake and implement such a study.

We would be pleased to supply our resources towards this end. We have appointed a special committee within our Association. This has no bearing on our representation before your Commission, sir. We have appointed this special committee to



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determine whether pharmaceutical manufacturers, as such, would be in a position of undertaking a program in order to assist in this area.

I would hesitate to attempt to give any suggestion as to what sort of result this committee might bring down because I doubt whether they will be able to come in with an effective and authoritative suggestion for our industry's implementation because first, we must find out precisely where the area of need exists and when we have the area of need and we know the cost factors involved, then we would take the necessary steps, accordingly.

COMMISSIONER FIRESTONE: Let us assume such a survey would delineate certain groups that are not in a position to pay for the drug costs either because of sub-standard income, or chronic illness, as you state. What are some of the ways in which your Association might feel that their needs could be taken care of? Would you, for example, feel that the Government should pay for the drug requirements of such families or would you feel some other system might be developed?

MR. CONDER: Yes, because I believe that in the matter of health, the question of the economic indigent has not arisen before to any great extent. Insofar as the welfare services are concerned, this will require very close study.

Certainly, we are not the people to determine the most effective and efficient method of handling that. The people to do that would be the





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Conder

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welfare specialists.

Possibly a system might be worked out through an extension of the health services. Possibly through a direct extension of the existing welfare agencies.

COMMISSIONER FIRESTONE: Could you visualize a system whereby the drug manufacturers would co-operate with government by making the drugs for these groups of families available at cost?

MR. CONDER: Yes, sir.

COMMISSIONER FIRESTONE: And then government paying the balance?

MR. CONDER: Yes, that has been suggested. As a matter of fact, it has been suggested by several of our companies that possibly a system might be worked out with retail pharmacists based on retail pharmacists supplying the products to the person in need and getting a rebate of cost from the manufacturer so that the manufacturer, in essence, would sell those products to the retail pharmacist at cost for this purpose.

THE CHAIRMAN: If that was done and if the manufacturer was going to maintain his profit level, he would have to recoup in another area.

MR. CONDER: Sir, that is one of the reasons why some of our companies, which are lukewarm to such a suggestion, have suggested that we would have to find out how extensive is this need.

COMMISSIONER FIRESTONE: I take it, if the drug manufacturers were to make it available to



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the pharmacists, the pharmacists in turn making it available to those that fall into that category, would you expect the retail pharmacists, in turn, to distribute it at cost or would you expect them to add their regular mark-up on such drugs?

MR. CONDER: Frankly, I haven't given it that much thought, sir. I would presume that we would expect that if we were giving a product at cost, that we would expect others connected with the servicing of that product to also give it at cost.

COMMISSIONER FIRESTONE: So that these drugs would still be made available to this group that you have described as economic indigents at cost both from the manufacturer and distributor level with the Government paying the actual cost? Is that understanding correct?

MR. CONDER: Yes, that is correct.

COMMISSIONER FIRESTONE: You feel a number of your companies would support such a proposal? Not necessarily all of them. You cannot speak for all of them.

MR. CONDER: I have, sir, good reason to believe that a number of them, depending primarily on the amount involved in this ---

COMMISSIONER FIRESTONE: You appreciate any survey that would be made, or analysis, might not give you the exact amount and, in fact, through practice and experience, the amount involved may be larger?

MR. CONDER: Yes, that is true.

COMMISSIONER FIRESTONE: It would be





October 1955

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rather difficult to guarantee such companies it will only be a certain amount and once a scheme is in operation, it would be more difficult to change and go back to the time where it wasn't in existence. Those companies are taking a certain risk in getting involved in such a program.

MR. CONDER: That is the reason for our study. While studies may not be conclusive, it would, at least, provide us with the estimate which would determine whether it is a matter of one-tenth of one percent or 15% because right now we have no way of knowing.

COMMISSIONER FIRESTONE: If it were 15%, would you feel it would be very difficult to implement it and if it were one-tenth of one percent it would be easy?

MR. CONDER: I would imagine that would be the case, yes sir.

COMMISSIONER FIRESTONE: May I now turn to the last paragraph on page 101 and I quote:

"The primary reason for the difference between hospital and retail prices is the economics involved in manufacturing and selling bulk to institutions as against manufacturing and selling small consumer-size packages through thousands of retail outlets from coast to coast."





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4 This statement refers to the differences that appear  
5 to exist in identical drugs being sold to hospitals and  
6 those through retail pharmacists to the consumer?

7 MR. CONDER: Yes, sir.

8 COMMISSIONER FIRESTONE: I have been  
9 asking the question of a number of retail pharmaceutical  
10 groups that have come before this Commission as to whether  
11 these groups could not band themselves together and  
12 through cooperative wholesaling purchase in bulk so that  
13 they should also have the advantages of mass buying  
14 similar to hospitals. What are your views?

15 MR. CONDER: It would depend on the  
16 product. In the first case, you will appreciate that the  
17 sales tax involved in products such as ours at the  
18 manufacturers' level are hidden costs and that the sales  
19 tax does increase with the general mark-up on the product  
20 right through to the end use. In addition, the hospitals  
21 normally will purchase in large bulk, in other words,  
22 in large quantities. It is inherently cheaper to supply  
23 in large quantities than in small package form of 24 to  
24 36 tablets. The saving in purchasing is not merely in  
25 the bulk alone, but also in the cost at the manufacturers'  
26 level. However, there is no doubt it could result in a  
27 saving; how much of a saving is difficult to say because  
28 you would be faced again with a further middle-man cost  
29 in the company which is purchasing from the manufacturer  
30 for the retailer.

COMMISSIONER FIRESTONE: A cooperative?

MR. CONDER: It would be in the same  
position as a wholesaler.





This statement refers to the differences that appear to exist in identical drugs being sold to hospitals and these through retail pharmacists to the consumer?

MR. COOPER: Yes, sir.

COMMISSIONER: I have been

asking the question of a number of retail pharmacists groups that have come before this Commission as to whether these groups could not band themselves together and through cooperative wholesaling purchase in bulk so that they should also have the advantages of mass buying without to hospitals, what are your views?

MR. COOPER: It would depend on the

product. In the first case, you will appreciate that the sales tax involved in products such as ours at the manufacturing level has been removed and that the sales tax does in some with the general mark-up on the product right through to the end user. In addition, the hospitals normally will purchase in large quantities in other words,

in large quantities. It is inherently easier to supply in large quantities than in small package form of 24 or 36 tablets. The saving in packaging is not merely in the bulk of the product, but also in the cost of the manufacturers' saving; how much of a saving is difficult to say because you could be comparing with a further middle-man cost on the company which is purchasing from the manufacturer for the retail.

COMMISSIONER: A cooperative

organization would be in the same

position as a wholesaler.



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TORONTO, ONTARIO

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COMMISSIONER McCUTCHEON: Or the manufacturer insofar as breaking down the bulk products into small packages.

COMMISSIONER FIRESTONE: Although, if it is a cooperative the member pharmacists all share in the middle-man's profit and if they so wished it could be passed on in terms of lower prices to the consumer unless the retail pharmacists want to make a profit twice, once at the middle-man level and at the distributor level. My question is, whether this bulk purchasing could be used to bring costs down to the retail level and, if I understand it, it is rather difficult.

MR. CONDER: There are many factors that enter into it.

COMMISSIONER FIRESTONE: Is that your judgment?

MR. CONDER: Yes, sir.

COMMISSIONER FIRESTONE: Has it been tried?

MR. CONDER: It has been tried to the extent that you just mentioned where a cooperative is formed, but the cooperative does purchase and turn it over to the retail pharmacists of which the retail pharmacist is a member and receives a dividend at the end of the year.

COMMISSIONER FIRESTONE: Do I take it that you as an industry would encourage the development of such wholesale cooperative sales organizations, or are you neutral?

MR. CONDER: We are neutral on that subject.





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COMMISSIONER FIRESTONE: May I now turn to Page 102, the last paragraph, in which you speak of current discussions which you are carrying on with the Food and Drug Directorate of the National Department of Health and Welfare in respect to regulations of methods of control procedures. Could you elaborate on what these discussions entail?

MR. CONDER: Yes, sir. We have commented on that in our submission if I have a second to find it. If I may comment, on Page 76 we state that the Food and Drug Directorate is presently establishing requirements for the manufacture and importation of pharmaceuticals which will tend to strengthen existing regulations. These proposed new regulations originated in the Food and Drug Directorate, and our Association as well as other interested groups have been working closely with the Directorate on the countless details involved.

In this connection we undertook an extensive study of what might be done to strengthen manufacturing requirements in Canada. The results of this study were then submitted to the Directorate. A considerable amount of work has since been done by our Association in this respect, and it is interesting to note that our companies are unanimously in favour of long and enforceable regulations.

COMMISSIONER FIRESTONE: You are saying through your recommendation on Page 105 that you are in favour of a compulsory system of setting up standards of controlling such standards?

MR. CONDER: Most definitely.





Concord 1944

WATER TOWER DISTRICT, MAY 1944

turn to take his, the last paragraph, in which you speak  
 of important questions which you are carrying on with the  
 Food and Drug Administration or the National Department of  
 Health and Welfare in respect to regulations of methods  
 of control procedures. Could you elaborate on what these  
 questions are?

on that in our association if I have a second to find it  
 in I say, on page 16 we state that the food and  
 Drug Administration is presently studying regulations  
 for the manufacture and distribution of pharmaceuticals  
 which will tend to strengthen existing regulations. These  
 proposed new regulations originated in the food and drug  
 Administration, and our Association as well as other  
 interested groups have been working closely with the  
 Administration in the course of this involved  
 in this connection we are working  
 extensive work in this regard as far as strengthening  
 manufacturing regulations in general. The results of  
 this study were then submitted to the Administration. A  
 case example of this is that the Association has been  
 Association in this regard, and it is interesting to  
 note that our committee has been successful in raising of long  
 and effective regulations.

the only point mentioned in the report is that you are in  
 favor of a regulatory system on setting up standards of  
 manufacturing and distribution.

W. J. ... last testimony.



Conder

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COMMISSIONER FIRESTONE: Is part of the recommendation which you have made to the Department of National Health and Welfare, does that include this compulsory achievement of standards and control?

MR. CONDER: Yes, sir.

COMMISSIONER FIRESTONE: May I now turn to Page 103, the third paragraph where you say:

"It is doubtful whether the public would stand for any measure which demanded that the cheapest medication be sold without regard for the reputation of the maker."

Now, some drugs are sold by larger companies who are proud of their reputation and some by smaller companies who are also proud of their reputation.

MR. CONDER: Yes, sir.

COMMISSIONER FIRESTONE: It just depends whose reputation, who is judge of whose reputation and I am just wondering whether the public should not be given a choice to buy drugs through some drug manufacturers who sell brand names and because of their reputation they feel those drugs must be higher-priced because of the work they have done. Some companies are quite happy about their own reputation, but are prepared to sell these identical or drugs of similar quality for a somewhat lower price. Would you not feel the public should be given a choice?

MR. CONDER: They have the choice now, sir, the average patient, it has been stated by many of



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CONFIDENTIAL - SECURITY INFORMATION

the recommendations which I have made to the Department of National Health and Welfare, does that include this commission's involvement of standards and controls?

MR. COLEMAN: Yes, sir.

CONFIDENTIAL - SECURITY INFORMATION

turn to 4, 1, 1, 1, the third paragraph where you say:

"It is doubtful whether the public would

stand for any measure which demanded that

the cheapest medication be sold without

regard for the reputation of the maker."

But, these things are sold by

companies who are known to be regulated on and some

by similar companies who are also known to be regulated

by the

MR. COLEMAN: Yes, sir.

where regulation, who is one of whose reputation and I

as just mentioned, where the public should not be given

the right to buy drugs through sales and manufacturers

and sell these things and some of their reputation

they feel a certain degree of responsibility and of

the new drug laws which these companies are quite happy

even though they are not, but are prepared to sell

these things in or out of control of the public and a

what does that mean? You have not lost the public's

the public's

MR. COLEMAN: They have the same law,

MR. COLEMAN: Yes, sir, the same law, it has been stated by many





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these companies which are comparatively new to the Canadian scene and as a result have not built up a reputation in the minds of the medical practitioners, that they may publish statements to the fact that they are selling by price and they urge the average person to go out and insist that his doctor prescribe the lowest-priced medication available. Now, we do not feel -- they can do this now --- we do not feel the majority of people want the cheapest medication possible or the lowest priced medication possible when it comes down to illness in their own family. We further do not believe ---

THE CHAIRMAN: Even if it is the same quality?

MR. CONDER: If the quality is the same, if the products are equivalent in every sense.

THE CHAIRMAN: In efficacy?

MR. CONDER: In efficacy. There is some reason but this is not necessarily the case, Mr. Chairman? We do not believe that the patient should be the person to tell the doctor what type of product he should prescribe. A doctor over the years uses a specific product because he comes to recognize most of the effect that product will have on his patients and as a result when he gives that product to a patient he is reasonably certain that this patient will respond in a certain way. If that patient comes up and says to that doctor and absolutely insists that he gives him a product of some other company, the doctor most certainly would be within his rights to refuse to serve that patient. The patient may do so if he wishes and quite a few people do apparently





these countries which are comparatively new to the  
American scene and as a result have not built up a  
reputation in the minds of the medical practitioners,  
that they may wish statements to the fact that they  
are willing to bring the best of the average person to  
us and insist that this is not a person in the lowest  
position of the medical profession. Now, we do not feel --  
they can do this now -- we do not feel the majority of  
people want the cheapest medical position in the lowest  
position of the medical profession. When it comes down to illness  
in the medical profession, we do not feel --  
I think they feel it in the same

way.

It is the quality of the

service, if the products are available in every case.

The quality of the

service is the quality of the

service that is not necessarily the case, is it not?

It is not a matter of the quality of the service, is it not?

To put it in another way, the type of service is the quality of the

A doctor, over the years, has a reputation and at the same

time, he has a reputation and at the same time, he has a reputation

that comes from a patient. He is not necessarily certain that

there is a reputation, is there?

That is not a matter of the quality of the service, is it not?

It is a matter of the quality of the service, is it not?

It is a matter of the quality of the service, is it not?

It is a matter of the quality of the service, is it not?

It is a matter of the quality of the service, is it not?



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from time to time. The whole problem is based on the fact that you may have two products approximately matching, the same chemical formula, but there may be a slight difference in effectiveness, the therapeutic action of those products and the doctor certainly is the best man to know whether this may be the case or not.

COMMISSIONER FIRESTONE: In the same paragraph you make reference to drugs being sold at a cut-rate or a discount; does your industry approve of such retailing methods?

MR. CONDER: No, sir, we do not. We were speaking of this not in retail alone, we were also speaking of it in supply. It has been known, for instance, that drugs may be purchased on the open market in Europe or New York which are discounted products which have been around for many years and they are unloaded and placed on the international market for sale. We ran into a case of this a few years ago when a load of products came on the market, they were in tablet form and the company knew there was something wrong with the products and could not put its finger on it. After a complete study of the tablets they found that the tablets were fractionally smaller, smaller than the type of tablet sold in Canada and contained a fractional difference in the active ingredient. This was just enough to show an adverse effect on the patient. These tablets have been on the market for many, many years and were being unloaded at what you might call distress sales practice.

COMMISSIONER FIRESTONE: I take it if the sort of regulation your industry is presently



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discussing with the Food and Drug Directorate are implemented, that which is harmful to the patient would be prevented from coming on the market. Therefore, my question relates to cut-rate and discount sales at the distributor levels, the level where the ordinary person purchases such drugs. What is the attitude of your industry to sales of drugs to the consumer at the cut-rate or discount?

MR. CONDER: We, of course, would sell these products to the cut-rate or discount retailer.

THE CHAIRMAN: You do not withhold your products from that type of market?

MR. CONDER: I am afraid if we attempted to do it we might be subject to legal action.

THE CHAIRMAN: You do not, in fact?

MR. CONDER: No.

COMMISSIONER FIRESTONE: In other words ---

MR. CONDER: I will qualify this by saying, to the best of my knowledge.

COMMISSIONER FIRESTONE: The fact that you continue to supply implies that you do not raise any objection to that method of merchandising, is that going a little too far in interpreting your position?

MR. CONDER: I believe it would. We have not taken a stand one way or another on it, but I do believe that our friends the retail associations take a dim view of this type of operation.

COMMISSIONER McCUTCHEON: It may mean you have a certain respect for the Director of the Food







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and Drug Directorate.

MR. CONDER: That is right.

COMMISSIONER FIRESTONE: May I now turn to the second paragraph on Page 106 where you suggest:

"...that the Government study the practicality of providing incentives to the chemical industry in order to establish more facilities in Canada for producing the raw materials used in pharmaceutical manufacturing."

What incentives do you have in mind?

MR. CONDER: I honestly do not know what could be done about this area, but you will note that it says to study the practicality. I do not know whether it would be practical or not, but it certainly deserves some investigation. The reason I say this is that sometime ago we undertook a survey to determine whether about 25 particular chemicals were manufactured in Canada and we did this on behalf of several of our companies. The returns coming in stated that these products were not available, but when these details started coming in, we received countless letters from our own companies stating if any of these products were manufactured in Canada or could be purchased in Canada they would certainly like to purchase their raw materials in Canada rather than abroad.



and Drug Information.

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then to the second paragraph on page 104 where you

say:

"...that the Government study the possibility  
of providing incentives to the chemical industry  
in order to establish more facilities in  
Canada for producing the new materials used  
in pharmaceutical manufacturing."

What incentives do you have in mind?

Mr. Gault: I honestly do not know what

could be done about this matter, but I will note that it  
is not to state the fact that I do not know whether  
it would be profitable or not, but it certainly deserves  
some investigation. The reason I say this is that  
sometimes we do undertake a survey to determine what  
is the production of chemicals was manufactured in  
Canada and we find on the basis of several of our  
companies that we are doing in several cases where  
products were not available, but when these  
started coming in, we were able to produce them from our  
own companies. I think it is a very good idea  
to have a study of this kind as it is possible in Canada  
they would certainly like to have some new materials  
in their industry.



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4 COMMISSIONER FIRESTONE: In other  
5 words, if I understand you correctly, sir, the basis  
6 for this recommendation is your belief that many of  
7 these processed materials could be produced in Canada  
8 for use by the pharmaceutical manufacturers in Canada?

9 MR. CONDER: Yes sir. Our problem  
10 is this, our market in Canada is small. In the primary  
11 production of chemicals the equipment needed for some  
12 of these things is extremely expensive, costly and  
13 requires considerable investment on behalf of the  
14 chemical manufacturer. The chemical manufacturer cannot  
15 afford to install in some of these lines this type of  
16 equipment in Canada to meet the Canadian market alone  
17 because some of this equipment requires extremely large  
18 volume to make its installation practical, and they  
19 would prefer to maintain their manufacturing facilities  
20 in places such as the United States, the U.K. or Europe  
21 where they have greater access to larger markets and  
22 are able to compete with competition from other suppliers.  
23 This is a disservice to the Canadian industry. We would  
24 like to have a much stronger primary industry in Canada  
25 than we have.

26 COMMISSIONER FIRESTONE: That is a  
27 very helpful opinion, Mr. Conder. Thank you very much.  
28 May I enquire or be permitted to ask you questions on  
29 the study that Brian Dixon did for the pharmaceutical  
30 manufacturing industry in Canada with respect to table  
3 on page 11?

MR. CONDER: I might add I am not  
an authority on this. If I can answer this I will. We



CONFIDENTIALITY REQUEST: In other

words, if I understand you correctly, sir, the basis

for this recommendation is your belief that many of

these processed materials could be produced in Canada?

For use by the pharmaceutical manufacturers in Canada?

Mr. GORDON: Yes sir.

Is this, our market in Canada is small. Is the primary

production of chemicals the equipment needed for some

of these things is extremely expensive, costly and

requires considerable investment on behalf of the

chemical manufacturer. The chemical manufacturer cannot

afford to install in some of these lines this type of

equipment in Canada to meet the Canadian market alone

because some of this equipment requires extremely large

volumes to make its installation practical, and they

would prefer to maintain their manufacturing facilities

in place, such as the United States, the U.K. or Europe

where they have greater access to larger markets and

are able to compete with competition from other suppliers

This is a disadvantage to the Canadian industry. It would

like to have a high degree of primary industry in Canada

that we have.

CONFIDENTIALITY REQUEST: That is a

very helpful opinion, Mr. Gordon. Thank you very much.

May I suppose you be permitted to ask you questions in

the early that Brian Dixon did for the pharmaceutical

manufacturing industry in Canada with respect to tank-

3 on page 11.

Mr. GORDON: I might add I am not

an authority on this. If I can answer this I will, as



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4 left this up to Dr. Dixon in all cases.

5 MR. HUME: He is not here. If we had  
6 known you might be interested in asking him some questions  
7 it might have been possible to have him here. If you  
8 ask a question Mr. Conder cannot answer we will see  
9 if Dr. Dixon could perhaps write a letter in answer to  
it.

10 THE CHAIRMAN: We could have the  
11 question put in written form.

12 MR. CONDER: We will be glad to bring  
it to the attention of Dr. Dixon.

13 COMMISSIONER FIRESTONE: If we turn  
14 to page 10 of your text, first. I shouldn't say your  
15 text it is Brian Dixon's study submitted to Mr. Conder  
16 on page 10 based on table 3 Mr. Dixon makes the  
17 following statement:

18 "When one considers that the all  
19 "manufacturing figures includes a number  
20 "of chronically depressed industries  
21 "and those which appear to be suffering  
22 "a secular decline, while the Pharma-  
23 "ceutical Preparations industry is in  
24 "a period of substantial growth, the  
25 "rate of 10.1% is not surprising or  
"extreme."

26 This 10.1% is a figure shown in table 3 on page 11 and  
27 it represents the net profit as a percentage of net  
28 worth of the pharmaceutical industry in 1958. Is that  
correct, sir?

29 MR. CONDER: That is my understanding.  
30





Conder

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That is the average.

MR. HUME: It is an average of five years.

COMMISSIONER FIRESTONE: It is an average for 1953 to 1958?

MR. HUME: Six years.

MR. CONDER: Six years based on net worth.

COMMISSIONER FIRESTONE: Based on net worth, are there any more up to date figures available since 1958 that has been done by your Association?

MR. CONDER: Not in this area, sir.

COMMISSIONER FIRESTONE: Taking, therefore, the figures that are now available according to this study that are listed it suggests that this 10.1% compares with the average for all manufacturing industries over the six year period of 5.3%. The difference between 5.3% for the manufacturing industry compares with 10.1% for the pharmaceutical industry makes a difference of 91%.

MR. CONDER: Might I add when I said no figures on this basis, I believe these were taken from the taxation statistics. We have further figures of our own surveys as mentioned in the early part of our brief, up to date figures showing the trend, but not net worth.

COMMISSIONER FIRESTONE: Not net worth, and you see when you examine the profit position of an industry figures on percentage of sales do not at all tell the full story. It is return on investments which





That is the answer.

Q. Now, it is an average of five

years.

COMMUNICATIONS DIVISION: It is an

average for 1948 to 1952?

MR. WARD: Yes, sir.

MR. WARD: Six years based on that

COMMUNICATIONS DIVISION: Based on that

month, and there are some up to date figures available

since 1948 that has been done by the Association?

MR. WARD: Not in this area, sir.

therefore, the figures that are now available

according to this study, it is listed it suggests that

this 10.1% compares with the average for all manufacturing

industries over the six year period of 5.8%. The

difference between 5.8% on the manufacturing industry

compares with 10.1% for the pharmaceutical industry was

a difference of 4.3%.

Q. Now, I don't see when I said

no figures on this basis, I believe these were taken

from the statistical data. I have further figures

of our own surveys as mentioned in the early part of

our report, as to date, it was showing the trend, but

not yet.

Q. Now, I don't see when I said

and you see when you examine the picture of an

industry figure is, increases of sales do not at all

tell the full story. It is rather of the picture.



Conder

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4 tells us the comparable story with other companies  
5 because you see if an industry with a large volume of  
6 business has a very small percentage of profit on total  
7 sales it may be a profitable business and a small  
8 industry with a small volume of sales and large percentage  
9 of profit may be on the verge of bankruptcy. It is  
10 more meaningful on the basis of return on investment.  
11 The pharmaceutical manufacturers have had approximately  
12 double the return on their investments than the  
13 manufacturing industry taken together. I am quite  
14 willing to admit there are good reasons for it and I  
15 think they are examined. This seems to be the effect  
16 that your study shows.

17 MR. CONDER: We must also realize  
18 that was conducted four years ago. The figures as represented  
19 are four years old. At that particular time you  
20 will notice the sales percentage of profit on the  
21 sales dollar after taxes was 6.3 whereas today it has  
22 dropped to 5.5 for 1960 and will be even lower for  
23 1961. If we show a decline on our profits after taxes  
24 based on the sales dollar then we might accept the  
25 possibility of a comparable decline on the net worth.  
26 Unfortunately that is as far as I am able to go at this  
27 time, sir, without more facts to go by.

28 COMMISSIONER FIRESTONE: We can only  
29 go so far. We can only use the evidence you have now.  
30 If you have any supplemental information we will be  
grateful to receive it. Now, sir, how would you or  
your industry feel about a prepayment plan for prescribed  
drugs?



...the comparison is made with other companies  
because you see it is industry with a large volume of  
business has a very small percentage of profit on total  
sales it may be a profitable business and a small  
industry with a small volume of sales and large percentage  
of profit may be on the verge of bankruptcy. It is  
some mechanical on the basis of return on investment.  
The manufacturing manufacturers have had approximately  
double the return on their investment than the  
manufacturing industry taken together. I am quite  
willing to admit there are many reasons for it and I  
think they are admitted. This seems to be the effect  
of your study of it.

Mr. ROBERT. We must also realize

that was conducted four years ago. The figures are correct  
are four years old. At that particular time you  
will notice the sales percentage of profit on the  
sales dollar after taxes was 8.3 whereas today it has  
dropped to 5.5. In 1963 it was 6.5 even lower in  
1961. If we show a decline on our profits after taxes  
based on the sales dollar then we must accept the  
possibility of a company's decline on the net worth.  
Informationally that is so. It is a fact to be a little  
time, and without some facts to go by.

...the only use the evidence you have is  
if you have any substantial information we will be  
careful to receive it. Now, sir, how would you  
your industry find about a payment plan for a year or





Conder

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4 MR. CONDER: We haven't discussed this  
5 in detail, Dr. Firestone. I wouldn't be in a position  
6 to comment on this right now. I would say our industry,  
7 generally speaking, would have nothing against it.  
8 They may prefer, some of these companies may prefer  
9 some sort of contributory plan.

10 COMMISSIONER FIRESTONE: Would it be  
11 too much to ask if there are occasions for your industry  
12 to consider the matter and if there were some views to  
13 pass those views on to us. We have had many, not many  
14 but a number of views on this subject and we would like  
15 to have the views of the drug manufacturers, after all  
16 you people are pretty much involved in whatever plan  
17 may be developed, if any.

18 MR. CONDER: We have our semi-annual  
19 meeting in approximately a week's time and I would be  
20 glad to bring this to the attention of the meeting and  
21 solicit an opinion and submit it to you in writing.

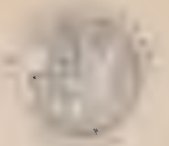
22 MR. HUME: So that we may be clear  
23 on the question, are you referring to a prepayment plan  
24 at the manufacturers or at the retail level?

25 COMMISSIONER FIRESTONE: I am referring  
26 to a prepayment plan which will facilitate for the  
27 consumers of drugs, the users of drugs, the acquiring  
28 of these drugs.

29 MR. HUME: The prepayment would be to  
30 the retail suppliers, to the consumer.

31 COMMISSIONER FIRESTONE: Not necessarily  
32 the retail supplier. There may be other methods of  
33 distribution, and in fact, there are other methods of





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... detail, Mr. Thompson, I would like to see in a position  
to comment on this right now. I would say our industry,  
generally speaking, would have nothing against it.

... they say, however, some of the companies may prefer  
some sort of a tributary plan.

... I would like to see it as  
too much to ask if there are conditions for your industry  
to consider the matter and if there were some views to  
give them a chance to say. We have had many, not many  
but a number of cases on this side and it would like  
to have the views of the drug manufacturers, after all  
now people are already working in a group plan  
may be desirable, if any.

... Mr. Thompson, we have our semi-annual  
meeting in approximately a week's time and I would like  
to bring this to the attention of the meeting and  
submit an opinion and submit it to you in writing.  
... I would like to see it as clear

... on the question, I am referring to a program that  
at the same time on a similar level.

... I am referring  
to a program plan which will facilitate for the  
consumers of drugs, the means of doing, the acquisition  
of these drugs.

... Mr. Thompson, I would like to see  
the plan, if possible, to the consumer,  
... I would like to see it as clear

... the retail system, this may be other methods of  
distribution, and in fact, there are many methods of



Conder

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distribution.

THE CHAIRMAN: Prepayment to the consumer.

MR. HUME: You are asking the Manufacturers' Association and we want it to be perfectly clear when Mr. Conder presents it to the manufacturers it is in the sense it would be prepayment not on the manufacturing level but it would be on the consumer level.

COMMISSIONER FIRESTONE: At the consumer level, but the drug manufacturers may have some views.

MR. HUME: I am sure they will.

COMMISSIONER FIRESTONE: As to what kind of plan, and they may have some suggestions of how to make such a plan more effective.

MR. HUME: I just wanted to be clear on the question so there would be no misunderstanding.

COMMISSIONER FIRESTONE: The next question, Mr. Conder, refers to a complaint that has been referred to not only here but in many other places about the drug prices being high. You feel that, perhaps, in the light of the facts which you have presented those complaints may not be justified. Whether they are justified or not they are there and the specific question I would like to put to you is: Can you think of specific steps which your association might feel would help in bringing drug costs down in Canada?

MR. CONDER: I don't know whether it would be possible for the industry to do so because our cost has been increasing and the price of drugs hasn't



THE COMMISSION: Prepared to do

nothing

MR. HUNT: You are asking the

the Federal Reserve Association, we want it to be completely

clear when it comes to the Federal Reserve

it is in the shape of a payment not on the

and accounting level but it would be on the Federal Reserve

COMMISSIONERS: At the

Commission, but the great question is how have some

MR. HUNT: I am sure they will

they would be very much interested in what

kind of plan, and they may have some new ideas of how

to make such a plan more effective

MR. HUNT: I have wanted to be clear

on the question of there could be no misunderstanding

COMMISSIONERS: The next

question, Mr. Hunt, is as to a condition that has

been referred to not only here but in many other places

about the new prices of gold, you feel that, as far

in the light of the fact that you have accepted those

conditions, you may be interested, what do they say

identified in the fact that they are the same as the question

I would like to put to you, for you think it is a

steps which you are considering as a first step in

to get the gold to be done in the

MR. HUNT: I think it is a

will be possible for the industry to do it

out but I am not sure and the price of gold



Conder

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4 been increasing in Canada. I think probably the greatest  
5 single benefit which could accrue to the people would be  
6 the elimination of the sales tax.

7 COMMISSIONER FIRESTONE: Could we  
8 explore this a little further. This is a helpful  
9 suggestion, sir. For example, you have been pointing out  
10 this morning the raw material and processing material --  
11 would the removal or reduction of duties on imported  
12 materials used by the pharmaceutical industry be helpful?

13 MR. CONDER: Yes, it could be, provided  
14 they are not of a class or kind manufactured in Canada.

15 COMMISSIONER FIRESTONE: With this  
16 qualification would you feel your industry would support  
17 such a policy?

18 MR. CONDER: As a matter of fact we  
19 are appearing before the Tariff Board at Ottawa right  
20 at the present time on this whole matter of tariff.

21 COMMISSIONER FIRESTONE: I take it  
22 from your general answer that the answer is yes.

23 MR. CONDER: That is correct.

24 COMMISSIONER McCUTCHEON: This is a  
25 little of variance with your recommendation there should  
26 be some assistance given to the chemical industry to  
27 manufacture chemicals in Canada.

28 MR. HUME: The class or kind, once the  
29 class or kind classification was made ....

30 THE CHAIRMAN: I think we have enough  
trouble without becoming the Tariff Board.

COMMISSIONER FIRESTONE: May I turn to  
the next question. You mentioned the expensive machinery





been interpreted in Canada. I think probably the greatest  
single benefit which could accrue to the people would be  
the elimination of the sales tax.

COMMITTEE: FIRST: Could we

eliminate this a little further. This is a helpful  
suggestion. For example, you have been pointing out  
that removing the raw materials and processing material --  
would the removal or reduction of duties on imported  
materials used by the pharmaceutical industry be helpful?  
MR. COLEMAN: Yes, it could be, provided  
that it was not a case of kind manufactured in Canada.

Question: Would you feel your industry would support  
such a policy?

MR. COLEMAN: As a matter of fact we  
are arguing before the Trade Board at Ottawa right  
at the present time on this whole matter of tariffs.  
COMMITTEE: FIRST: I take it

from your general answer that the answer is yes.  
MR. COLEMAN: That is correct.

COMMITTEE: SECOND: This is a

matter of variance with your recommendation that there should  
be some assistance given to the chemical industry to  
manufacture chemicals in Canada.

MR. COLEMAN: The case of kind, on the one  
hand, on the other hand, was not...

MR. COLEMAN: I think we have enough

probably without going on the other hand.

the next question. You mentioned the expensive and costly



Conder

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4 and equipment, much of which you have to import from  
5 abroad. Would the reduction of tariffs on machinery  
6 and equipment used by the pharmaceutical industry again  
7 be a factor reducing the costs of operation?

8 MR. CONDER: It would be a most helpful  
9 factor if that could be done because it would give  
10 further impetus to strengthening manufacturing in this  
11 country.

12 COMMISSIONER FIRESTONE: You feel your  
13 industry would so recommend?

14 MR. CONDER: We would be pleased to  
15 recommend that, I am certain.

16 COMMISSIONER FIRESTONE: How about  
17 the question of additional allowance for research in  
18 Canada in the pharmaceutical field?

19 THE CHAIRMAN: That is not an invitation  
20 that we are going around with a bagful of money offering  
21 these things.

22 MR. CONDER: We would like to see  
23 every incentive possible given to improving and furthering  
24 research in this country. I would hesitate to go into  
25 what might be done at this stage without considering  
26 in further detail what effect this recent budget  
27 has had on our companies. We will be discussing this  
28 item at our forthcoming meeting.

29 COMMISSIONER FIRESTONE: May I leave it  
30 like this, the Chairman is quite right, this is general  
information in an attempt to ascertain what can specifically  
be done to bring drug costs down, whether these complaints  
are justified or not. As a Commission we would like to





Conder

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4 see what the possibilities are. We don't know whether  
5 we could accept them or not, but, at least we should  
6 know what the possibilities are. It would help, Mr.  
7 Conder, if on further consideration if you or your  
8 associate members of the industry have specific  
9 proposals that you feel you could submit to us to help  
10 us develop our recommendations we would be grateful to  
11 you. I will leave it on this basis.

12 MR. CONDER: Yes.

13 COMMISSIONER FIRESTONE: My last  
14 question, Mr. Conder, relates to a recommendation which  
15 has been made to this Commission by the Government of  
16 the Province of Alberta. I presume you are familiar  
17 with recommendation 4 contained in that submission in  
18 which the Government of the Province of Alberta suggests  
19 and I quote:

20 "That with a view of combating the  
21 "high cost of drugs the Commission  
22 "should recommend the set up of a  
23 "federal agency with power and  
24 "direction".

25 Now, sir, do you recall that recommendation or shall I  
26 read it?

27 MR. CONDER: I don't recall it.

28 COMMISSIONER FIRESTONE: May I read  
29 you the first paragraph, subparagraph 1 of their  
30 recommendation:

"To examine the revenue cost position  
"of individual drugs so as to determine  
"the cost as well as the profits of





see what the possibilities are. We don't know whether  
we could accept them or not, but, at least we should  
know what the possibilities are. It would help, for  
instance, if on further consideration if you or your

associate members of the industry have already  
proposed that you feel you would submit to us to help  
us develop our recommendations we would be grateful to  
I will leave it on this point.

Very truly yours,

W. L. East

question, in London, related to a recommendation which  
has been made to this Government by the Government of  
the Province of Alberta. I believe you are familiar  
with recommendation contained in that submission in  
which the Government of the Province of Alberta suggests  
and I quote:

"That with a view to co-ordinating the  
"the cost of the various commissions  
"be placed under the control of a  
"central agency which covers all

Now, sir, you would think that a resolution of this kind  
would be

Very truly yours, W. L. East

For the first time, I am glad to hear of their

The committee has now been set up to  
investigate the matter and it is the  
the cost is well within the limits of



Conder

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"manufacturing and marketing."

Would your industry be in favour of the establishment  
of such a federal agency with this particular function  
as recommended to this Commission by the Government  
of Alberta?



"Manufacturing and marketing."

While your industry is in favor of the establishment  
of such a Federal agency with this particular function  
as recommended to this Commission by the Government  
of Alberta.



Conder

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MR. CONDER: I would suggest, sir, that probably a question of this type appearing in here would show a lack of understanding and appreciation of our particular industry. It is a sheer impossibility to take an individual product and use that as an example of the operations of a company.

By the same token, it would be extremely difficult to examine the revenue position of a drug and examine the cost and marketing, because by the time you have finished the whole position of that drug may have changed so radically as to have no bearing on the opinion originally held.

COMMISSIONER McCUTCHEON: Your industry would be opposed to that recommendation?

MR. CONDER: Yes, it would not be practical.

COMMISSIONER FIRESTONE: In paragraph (ii):

"To serve as a source of information for physicians, pharmacists, hospitals and others concerning new drugs, modifications and combinations, so as to eliminate or moderate the present cost to manufacturers of bringing such drugs to the attention of the people concerned;"

MR. CONDER: I believe we have covered that already, sir.

COMMISSIONER FIRESTONE: And your answer would be?







Conder

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MR. CONDER: We would have nothing against the establishment of such a central source of information, but frankly, we do not believe it would be practical or of value.

COMMISSIONER FIRESTONE: The third recommendation:

"To encourage, in the interest of price savings, the widest use of quality generic drugs by physicians and retail pharmacists."

MR. CONDER: I believe that we have two paragraphs in our brief that touch on this whole generic name basis. Regardless of the move by the Province of Alberta to introduce a system of substitution and equivalency, we are firmly against the principle of equivalency, and that the sale of all drugs should be by generic name is based on the philosophy that all drugs are equivalent, which is incorrect.

COMMISSIONER FIRESTONE: And the fourth sub-paragraph:

"To assure that The Patent Act, The Food and Drugs Act, or any other legislation, does not stand in the way of any steps which might be taken to reduce the cost of drugs."

MR. CONDER: Yes, we would certainly be in favour of this, although I would doubt that there is legislation on the books which is standing in the way of any steps which might be taken to reduce the



Mr. [Name] would have nothing  
 against the establishment of such a central source of  
 supply, but, possibly, we do not believe it would  
 be a source of value.

"To encourage, in the interest of  
 price savings, the widest use of  
 quality generic drugs by physicians  
 and retail pharmacists."  
 Mr. [Name] believes that we have  
 a responsibility to our public that counts on this whole  
 generic drug policy. The success of the move by the  
 province of Alberta to introduce a system of substitution  
 and equivalence, we are firmly against the principle of  
 equivalence, and that the sale of all drugs should be  
 on a price basis is based on the philosophy that all  
 drugs are equivalent, which is incorrect.  
 (Name of the speaker) And the

It is saying that in front of  
 the fact that the fact is, in any  
 other words, it does not stand  
 in the way of any steps which  
 might be taken to reduce the  
 cost of drugs."

Mr. [Name]: Yes, we would certainly  
 be in favor of it, and I would doubt that  
 there is anything in the fact that it is a  
 fact that we have to be able to reduce the



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cost of drugs, because we don't believe that the cost of drugs is out of line in Canada today.

THE CHAIRMAN: There was a subject mentioned here yesterday or the day before about the practice of some drug distributors or manufacturers, but I am taking those words as being synonymous at the moment, of replacing time-dated drugs on the retailers' shelves. Is that widespread in Canada?

MR. CONDER: Oh yes, sir. They will assist the pharmacist in maintaining his stocks and, in some cases, the pharmacist will return the merchandise. This is called a returned goods policy in the industry. In other words, if a pharmacist has in stock a medication which has, say, a life of 12 months, for example, and it comes up to the expiry date of that product; that product must be returned to the manufacturer and we have what we call a returned goods policy in the industry whereby the retail pharmacist returns that product to the manufacturer for full credit.

THE CHAIRMAN: And he gets credit? He does not have to take new goods in substitution?

MR. CONDER: In most cases, direct credit.

THE CHAIRMAN: In that case it results in a lowering of the inventory?

MR. CONDER: Yes, it does.

THE CHAIRMAN: And in that sense it has a direct bearing on this matter of inventory becoming out of date.

Well, thank you very much, Mr. Conder







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TORONTO, ONTARIO

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and Mr. Hume.

As I mentioned earlier, we are grateful to the industry for the co-operation that we have had from you, and for your attendance here today and the manner in which you have dealt with the questions this morning.

MR. CONDER: Thank you for your courtesy, sir.





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THE SECRETARY: Mr. Chairman, the next submission is that of the Medical Section of the Canadian Pharmaceutical Manufacturers' Association, and Dr. Stewart will introduce the group. It will be known as Exhibit 292.

--- EXHIBIT NO. 292: Submission of the Medical Section of the Canadian Pharmaceutical Manufacturers' Association.

SUBMISSION OF THE MEDICAL SECTION OF THE  
CANADIAN PHARMACEUTICAL MANUFACTURERS'  
ASSOCIATION.

Appearances: Dr. P.B. Stewart  
Dr. J.M. Parker  
Dr. C.W. Murphy  
Mr. F.R. Hume, Q.C.

MR. HUME: Mr. Chairman, again my function is only to introduce the gentlemen who will be presenting this submission.

On my immediate left is Dr. P.B. Stewart, who is the Medical Director of Geigy Pharmaceuticals from Montreal. On my right is Dr. C.W. Murphy, who is the Medical Adviser of Ciba Company Limited, from Dorval and on Dr. Stewart's left is Dr. J.M. Parker, Director of Research of the Frosst Company of Montreal.

Dr. Stewart is presenting the recommendations and summary of the brief.

DR. STEWART: The Medical Section of the Canadian Pharmaceutical Manufacturers' Association is a group of physicians working as full or part-time members of a Medical Department of a company which is a







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member of the Association, and whose main functions are to:

- a) Act in an advisory capacity to Management on medical matters.
- b) Organize and supervise clinical investigations.

The contribution of new drugs to improve health care has been described. The proper place of a new drug in the therapy of disease can only be determined by careful drug evaluation trials.

At all stages of the trials, risks must be kept to a minimum. The steps in the development of a new drug, which involve extensive animal toxicology before it is considered for its initial or pilot trials, are described. The initial or pilot drug trials on humans are mainly concerned with determining the clinical effectiveness of a new drug. Once this has been defined, then the nature and incidence of untoward toxicity must be ascertained. It is to these two fields that members of the Medical Section are devoting time and energy, so as to minimize any risk to the patient, while at the same time preserving the benefits derived from the new drug. Safety and effectiveness in a new drug can only be established through careful and extensive clinical trials. To obtain this vitally important information, members of the Medical Section work with recognized specialists and experienced members of the medical profession.

Due largely to the effects of new drugs discovered or developed by the pharmaceutical





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industry, the course of mental illness, infectious diseases, and diabetes has been substantially changed for the better. It is believed that, in the future, new drugs will offer more hope in cancer, auto-immune diseases, and degenerative diseases. A tabulated survey of drugs under investigation in Canada in the years 1959, 1960 and 1961 shows that drug trials presently encompass a wide range of compounds designed for the treatment of many different diseases. The number of new drugs under investigation has increased from 185 in 1959 to 232 in 1961, the number put on the market has fallen from 79 in 1959 to 67 in 1961. We interpret this to show that more care and discrimination is being used before new drugs are marketed.

The Medical Section feels strongly that in order to continue the forward progress of pharmaceutical research, and at the same time reduce the chance of serious toxicity in new compounds, it is essential that more time and effort be given by universities and their medical schools to training physicians in the methodology of drug trials. We would, therefore, make the following recommendations.

#### RECOMMENDATIONS

In view of the important contribution to the health of the Canadian people to be made by the development of new and better drugs, and in view of the need to evaluate the effectiveness of these drugs, the Medical Section of the Canadian Pharmaceutical Manufacturers' Association recommends:

- 1) That units be established for the







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clinical evaluation of new drugs.

2) That one or more of these units should also be prepared to train physicians in the techniques of new drug evaluation by offering detailed courses in pharmacology, biochemistry and methodology.

3) That the units for drug trials should be related to University Medical Faculties and should be integrated with postgraduate medical education because the skilful use of a new drug in therapy requires, on the part of the practising physician, knowledge and understanding of its effectiveness, toxicity, metabolism and excretion.

THE CHAIRMAN: Thank you very much, Dr. Stewart. As you may know, we have a medical education project as one of our major studies, under Dr. MacFarland. Initially this recommendation will go to that committee.

COMMISSIONER FIRESTONE: Dr. Stewart, I find these are interesting recommendations, particularly the one mentioned in paragraph 37, sub-paragraph 1), where you speak of units to be established for the clinical evaluation of new drugs. I wonder whether you could elaborate a little, sir, by telling us where such units would be established, by whom, who should pay for them, etc.?





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DR. STEWART: Well, we feel, sir, that these units would include personnel who have a full understanding of chemistry, biochemistry and pharmacology and, in addition, they should have physicians with a fairly wide background of drug effects, who would be able to take a compound into a medical centre with the idea of assessing its effectiveness.

I would like to stress, I think, to this Commission, perhaps I detected in your previous questioning, I think as an industry we are mainly concerned with the biological effects of chemicals, rather than the chemical structure itself. The chemical structure itself is only important to us if it produces a biological change. Therefore, we have very little guidance from chemical structure as to what it will produce in amount, and certainly there are specious differences which further complicate the picture.

THE CHAIRMAN: The units you refer to in 1), are they the same units you refer to in 3)?

DR. STEWART: Yes, I think I used the word just to bring these various disciplines into a centre.

THE CHAIRMAN: And you say the place for that would be in a university school?

DR. STEWART: I would hope so.

COMMISSIONER McCUTCHEON: And the evaluation would be done in a teaching hospital?

DR. STEWART: Yes, sir.

COMMISSIONER FIRESTONE: How would the







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results of that clinical evaluation be made available to those for whom you are making it?

DR. STEWART: One of our results we hope for is the publication of scientific papers. We regard this as the final court of appeal of all knowledge and claims for drugs. We encourage, and we work towards the publication of results from various centres into the scientific literature, and therefore, we hope that doctors, who are usually pressed, but they do read widely, will take these publications and assess them on this basis.

The other form that the dissemination of knowledge is made available to the medical profession is through post-graduate courses, and the last one is the presentation of scientific papers at medical scientific meetings.

COMMISSIONER FIRESTONE: I gather you were in the room when we were discussing the subject of a drug information centre?

DR. STEWART: Yes, sir.

COMMISSIONER FIRESTONE: To make available up-to-date information and evaluation to practising physicians. I take it if such a centre were established it could draw on these clinical evaluation units for information and results, in order to provide that service of information so that this would, perhaps, give you a practical outlet to bring the results of this clinical work to the medical profession?





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DR. STEWART: Yes sir.

COMMISSIONER FIRESTONE: Would you feel that such a co-operative arrangement would work?

DR. STEWART: I see no objection in principle. I think that the organization you envisage would probably be a natural development of the one we recommend. Probably this comes first.

COMMISSIONER FIRESTONE: You have been very helpful Dr. Stewart, thank you.

COMMISSIONER BALTZAN: Dr. Stewart what you have described on the recommendations, paragraph 37, is that not actually in progress at the present time except not organized in the way you speak of?

DR. STEWART: I think there is a ground swell amongst the profession to get information and evaluation of drugs done by people they know in the universities of which they are familiar.

We are disturbed a little bit by the fact there is a lack of trained personnel to staff these units. Very few people, as you will probably be able to tell more than I would, really have any training in medical school and drug evaluation, trials or methodology especially where drugs involve subjective symptoms rather than something that can be measured.

This gap is now being filled, but it is slow.

COMMISSIONER BALTZAN: That is a matter one would take up, especially your people, with the Faculties of the University?

DR. STEWART: Yes sir.





Dr. Stewart: Yes sir.

Dr. Stewart: Would you

like to have a representative of your group

Dr. Stewart: I see no objection in

Dr. Stewart: I think that the organization you have

which is a natural development of the one

which is a natural development of the one

been very helpful, Dr. Stewart, thank you.

Dr. Stewart: I have observed on the representative, Dr. Stewart,

Dr. Stewart: I think that the organization you have

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4 COMMISSIONER BALTZAN: In order to  
implement that sort of specialized field?

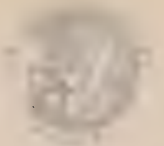
5 DR. STEWART: Yes sir.

6 COMMISSIONER BALTZAN: Now then, on  
7 the question of the clinical control and methodologies,  
8 you want to see a better control system as against the  
9 kind of things that physicians experience today when  
10 these detail people come along and say that our company  
11 will provide you with so much of this kind of medication,  
12 and follow this thing through and write us back a report  
of the experience.

13 You want something better than that  
14 helter-skelter arrangement?

15 DR. STEWART: Yes sir. We would want  
16 to encourage more control trials. In other words, trials  
17 which would give the definitive answers rather than  
18 testimonials or just an impression of something where  
19 evidence could be accumulated, sifted and statistically  
analyzed and see if there is a demonstrable change.

20 COMMISSIONER BALTZAN: One would not  
21 say at this stage that things are being put on the market  
22 without things being reasonably well studied in spite  
23 of the demands you are making here. I know in making  
24 these suggestions it would change only in the form  
25 of organization and the information finally collected  
26 would then be submitted to the producers of this  
27 particular drug. It could be published by the individuals  
28 who have carried on an experimentation trial in the  
29 hospital over a period of so many months, over so many  
30 dozens or thousands of cases.



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DR. STEWART: Yes sir.

COMMISSIONER BALTZAN: And the source of information then would become available, not necessarily through a centre, but some of this is already available in our own practice today.

DR. STEWART: Yes sir.

COMMISSIONER BALTZAN: You read things in an accredited journal. Look at the author and you make a drug evaluation on that basis?

DR. STEWART: That is correct sir, yes. Rather than recommending just a central agency pushing all the knowledge, we still are determined that a basis of judging this should be in the scientific literature, a paper by the individuals who have conducted the trial.

COMMISSIONER BALTZAN: Dr. Stewart, on page 10 could you elaborate a little bit on a most interesting declaration and that is "the number of new drugs under investigation has increased from 185 in 1958 to 232 in 1961, the number put on the market has fallen from 79 in 1959 to 67 in 1961. This shows that more care and discrimination is being used before new drugs are being marketed".

Would you care to elaborate further?

THE CHAIRMAN: Is that necessarily so, that you just handled more drugs without initial merit?

DR. STEWART: You are welcome to your interpretation.

THE CHAIRMAN: I mean drugs under investigation would be trial drugs?

DR. STEWART: Yes sir.







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THE CHAIRMAN: That is the purpose of the investigation and shows care.

DR. STEWART: One would expect on first principles if the number under investigation rose, then the number marketed would also show a proportionate rise. I think that is the interpretation I would put on.

THE CHAIRMAN: It wouldn't necessarily be so. Just means more initial activity.

DR. STEWART: All right. It has fallen in spite of a rise in drugs being actively considered, which we interpret and have other evidence which we cannot put into words as the pharmaceutical industry being more conscious of its responsibilities in producing new drugs. Taking more time. Increasing its medical departments. The number has risen in the last few years from eight or ten physicians in industry in Canada to approximately 35. Now this, we think, has led to more careful evaluation and hence a further delay or discarding of drugs.

COMMISSIONER BALTZAN: And yet it is interesting, if true, that those that are now available are being used more and more. In other words appears to be a lot more prescribed, a lot more consumed. What is the explanation for that? Too much prescribing? Patients too consuming? Have you any ideas on that? Would you care to express an opinion?

DR. STEWART: Well I haven't any real explanation Dr. Baltzan. I would think the increase in population is one factor which would do it. I would





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4 think that people would only keep using it if the drugs  
5 were effective and they are getting some effects they  
6 desire. Therefore, they will keep using them in  
7 increasing quantities. Apart from this, I am not  
8 competent to discuss the increase.

9 COMMISSIONER BALTZAN: The reason I  
10 put the question is because certain realities and that  
11 is, you frequently hear or we hear about putting a  
12 deterrent factor on the use of drugs.

13 THE CHAIRMAN: Deterrent cost factor.  
14 Not any other form of deterrent.

15 COMMISSIONER BALTZAN: There will be  
16 a limitation of the use of drugs, take it from the cost  
17 factor particularly, and of course the cost mounts when  
18 taken unnecessarily and that is the reason I wanted to  
19 bring this out. Thank you very much.

20 THE CHAIRMAN: Thank you very much  
21 Dr. Stewart. We will rise now until two o'clock.

22 ---Luncheon adjournment.  
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---On Resuming at two o'clock.

THE SECRETARY: Mr. Chairman, the next submission is that of the Ontario College of Pharmacy which is to be known as Exhibit 293.

---EXHIBIT NO. 293: Submission of Ontario College of Pharmacy.

S U B M I S S I O N O F  
THE ONTARIO COLLEGE OF PHARMACY

APPEARANCES:

MR. G. G. CALDWELL  
MR. P. D. ISBISTER  
MR. P. T. MOISLEY  
MR. W. ISAACSON  
MR. H. A. JESSUP

MR. MOISLEY: Mr. Chairman and Members of the Commission, with your permission I will read our conclusions and recommendations.

There is a definite need for expansion of health services to certain segments of the population of Ontario and we therefore recommend:

1. THAT the Commission consider the establishment of a comprehensive health care program.

Provision of medical care alone does not constitute comprehensive health care. The medical practitioner must at all times be provided with the therapeutic tool of drugs when required for treatment of his patients. We therefore recommend:





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2. THAT the Commission consider as one of the minimal initial requirements of any plan the provision of pharmaceutical services by pharmacists registered and in good standing in the province in which the services are provided.

The participants in any health care program must be free to choose the pharmacist from whom they wish to procure benefits and we therefore recommend:

3. THAT the Commission strongly affirm in its findings that drug benefits be available to participants through all legally established pharmacies for the distribution of drugs and medicines and that there be no restriction on the participants' choice of pharmacy.

The prescriber of drugs must be free to choose the medication which he deems to be in the best interests of his patient without any limitation on the range of such choice and we therefore recommend:

4. THAT the only restriction on drug benefits in any health care program be limitation of the quantity prescribed on each prescription and the number of repeats of each prescription.

It is evident that all health plans studied require or should require some form of economic control as a deterrent factor to overutilization of drug benefits and we therefore recommend:

5. THAT the Commission consider some method of requiring each patient to contribute a nominal amount for each prescription.

It must be recognized that the persons supplying the services in any health care program would be





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2. THAT the Commission consider as one of the principal ethical requirements of any plan the provision of pharmaceutical services by pharmacists registered and in good standing in the province in which the services are provided.

The participants in any health care program must be free to choose the pharmacist from whom they wish to procure benefits and to therefore recommend THAT the Commission strongly affirm in

its findings that drug benefits be available to participants through all legally established pharmacies for the distribution of drugs and medicines and that there be no restriction on the pharmacist's choice of pharmacy. The prescriber of drugs must be free

to choose the medication which he deems to be in the best interests of his patient without any limitation on the range of such choice and we therefore recommend:

3. THAT the only restriction on drug benefits in any health care program be limitation of the quantity prescribed on each prescription and the number of refills of each prescription.

It is evident that all health plans established by law or should require some form of economic control as a permanent factor to overutilization of drugs and as the basis for a sound health care system.

4. That the Commission consider as one of its principal ethical requirements of any plan the provision of pharmaceutical services by pharmacists registered and in good standing in the province in which the services are provided.

5. That the Commission consider as one of its principal ethical requirements of any plan the provision of pharmaceutical services by pharmacists registered and in good standing in the province in which the services are provided.



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the most logical persons to operate such a program and we therefore recommend:

6. THAT the Commission recommend that any program resulting from its studies be inaugurated, developed and fully administered by an independent board or commission, composed largely of representatives of the professions supplying those services and that all such professions be represented on the board or commission.

There is a definite need for government assistance in the financing of any health care program. This need varies amongst different segments of the population and we therefore recommend:

7. THAT the Commission study the possibility of a graduated subsidization in any health care program and a system of cost sharing between federal and provincial governments.

The institution of any health care program will create an increased need for personnel in the professions providing services, particularly at hospital and governmental levels and we therefore recommend:

8. THAT the Commission consider as one of its recommendations federal and provincial government assistance to students training in the health professions in the form of scholarships, bursaries or through direct subsidization.

THE CHAIRMAN: Thank you, Mr. Moisley. Your first recommendation, the establishment of a comprehensive health care program, just what have you in mind in that expression "comprehensive health care program"?

MR. MOISLEY: Well, I think the feeling







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of the College is that any plan should cover those segments of the population which, shall we say, are in dire need of such coverage.

THE CHAIRMAN: Is that your comprehensive, you are talking now in numbers of people?

MR. MOISELY: That is correct.

THE CHAIRMAN: People rather than of services?

MR. MOISELY: Yes. It has been laid out in the brief that there should be those types of persons, we feel, should be covered. I believe we feel that there is a large group of people in the Province that can well afford any type of plan to pay the full amount themselves. We feel, of course, the service, medical, pharmaceutical, we have mentioned, those are the minimum requirements of any plan.

THE CHAIRMAN: Well, I do not want to misunderstand your or misapply what you have said, but your term "comprehensive", are you taking in all people?

MR. MOISELY: Yes.

THE CHAIRMAN: So is it implicit in what you are saying that what you want is a plan that will be mandatory for all to belong?

MR. MOISELY: I think, sir, that when "mandatory" enters into the picture ----

THE CHAIRMAN: Or compulsory?

MR. MOISELY: No, I do not believe so.

THE CHAIRMAN: We have to take it as one or the other.

MR. MOISELY: I think we are using the





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of the college is that we should cover those  
segments of the population which, shall we say, are in  
dire need of such coverage.

THE CHAIRMAN: Is that your conclusion?

Yes, you are talking now in terms of people

Mr. Chairman: That is correct.

THE CHAIRMAN: People rather than on

individuals

Mr. Chairman: Yes, that is correct.

Now in the panel that there should be those types of  
persons, we feel, should be covered. I believe we feel  
that there is a large group of people in the Province that  
are well off and any type of plan to pay a full amount  
themselves. We feel, of course, the service, medical,  
educational, we have mentioned, those are the main  
and interests of any plan.

Well, I do not want to

disagreement with you or disagree with what you have said, but  
you are talking about, the you talking in a general

Mr. Chairman: Yes.

THE CHAIRMAN: So as to clarify it

What you are saying is that what you are saying is that

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word "comprehensive" as to service.

THE CHAIRMAN: All right. What service are you talking about?

MR. MOISLEY: Well, particularly in the field of the medical services and the pharmaceutical services and I think possibly we could leave it to the judgment of the Commission, the other services.

THE CHAIRMAN: We would like to know what you think should be there. Are you motivated -- what interest motivates you to say medical and pharmaceutical, what about nursing and dentistry?

MR. MOISLEY: Yes, nursing by all means I believe should be covered. In sitting and listening to the submissions made to the Commission, possibly certain dental services but here again that is a personal opinion. I feel I am not in the position to express an opinion as far as full dental services.

THE CHAIRMAN: Comprehensive is in terms of services?

MR. MOISLEY: That is right.

THE CHAIRMAN: What about the area of population to be covered, who is to be included in this program that you recommend?

MR. MOISLEY: Again, I think we have said in our brief how that should be taken care of. On Page 16 we have priority one, welfare groups and so on down the list of priorities.

THE CHAIRMAN: Those are five groups which you mean to include in this, you are taking priorities, but having exhausted the priorities where do you go?





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MR. MOISLEY: Well then, we feel it should be made available on a voluntary plan possibly for those who wish it.

THE CHAIRMAN: You see just how indefinite it is "on a voluntary plan". If you have position what is your position? If you have not a position, just say so and that is the end of it. We are not here to tell you that you must necessarily take a position.

MR. MOISLEY: Well, we really do not, after these five priorities are taken care of, we do not really take a position.

THE CHAIRMAN: You feel the rest of them will take care of themselves?

MR. MOISLEY: That is the general feeling.

THE CHAIRMAN: And you feel since they are able to take care of themselves it is up to them?

MR. MOISLEY: That is the way I feel personally about it.

THE CHAIRMAN: What about the College of Pharmacy?

MR. MOISLEY: Mr. Jessup and Mr. Isaacson, two members of our committee are here and I think it is our general feeling. However, they may speak for themselves.

MR. JESSUP: I would agree with what Mr. Moisley says on that.

THE CHAIRMAN: Now then, in this program that you would like to see implemented you say that there should be some deterrent factor?





Witness

Q. Now, tell them, we are in

and it is a kind of a voluntary, but possibly the  
we are with it.

Q. Now, tell them, we are in a position  
to have a position? If you have not a position, just  
say so and that is the end of it. We are not here to tell  
you that you must necessarily take a position.

MR. MCINERNEY: Well, we really do not,  
after all, we have positions are taken care of, we do not  
really have a position.

Q. Now, tell them, we are in a position  
to have a position? That is the general

MR. MCINERNEY: And you know since they  
are able to take care of themselves it is up to them  
to take care of themselves.

MR. MCINERNEY: What about the college  
at the time?

Q. Now, tell them, we are in a position  
to have a position? We are in a position to have a position

Q. Now, tell them, we are in a position  
to have a position? We are in a position to have a position

Q. Now, tell them, we are in a position  
to have a position? We are in a position to have a position



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MR. MOISLEY: Yes, sir.

THE CHAIRMAN: And you go on to say "requiring each patient to contribute a nominal amount for each prescription". Just what do you have in mind there?

MR. MOISLEY: Well, in almost all plans that we have reviewed there is a deterrent factor in them inasmuch as the patient is ---

THE CHAIRMAN: Are you talking about deterrent factor or a co-insurance factor? Which one are you aiming at? Are you trying to inhibit the purchasing of drugs or are you trying to get more revenue for the operation of the plan?

MR. MOISLEY: I just do not know how to express it.

THE CHAIRMAN: You see, there is a difference.

MR. MOISLEY: We think that the deterrent factor when we speak of it in this manner, a patient should be required to pay some small amount for each prescription.

THE CHAIRMAN: Why?

MR. MOISLEY: There is a trend in plans of this type that when people receive certain benefits for which they do not contribute anything that they tend to over-utilize things.

THE CHAIRMAN: Now you are talking about a true deterrent?

MR. MOISLEY: Yes.

THE CHAIRMAN: In this program,



THE CHAIRMAN: Yes, sir.

THE CHAIRMAN: And you go on to say

"producing with patient no demonstrable nominal amount  
for each prescription". Does that do you have in mind

yes?

MR. MOULTON: Well, in almost all cases

that we have reviewed there is a definite factor in them

inasmuch as the patient is --

THE CHAIRMAN: Are you talking about

amount of money or a co-insurance factor? Which one

are you talking about? Are you trying to inhibit the purchas-

ing of drugs or are you trying to get more revenue for

the community? Is that right?

MR. MOULTON: I just do not know how

to express it.

THE CHAIRMAN: You see, there is a

little more.

MR. MOULTON: We think that the determi-

nation of a drug is made in this manner, a patient

should be paid for in part some small amount for each

prescription.

MR. MOULTON: There is a trend in place

of this type that when certain certain benefits for

which they do not contribute anything that they tend to

over-utilize things.

THE CHAIRMAN: Now you are talking

about a little better

MR. MOULTON: Yes.

THE CHAIRMAN: In this program,



Moisley 10681

recommendation number 7 where you say the Commission study the possibility of graduated subsidization in any health care program and a system of cost sharing between Federal and Provincial Government -- we need not be concerned with that for a moment. What have you in mind about this subsidizing this health care program?

MR. MOISLEY: Well, that is pretty hard --- that is a pretty broad question.

THE CHAIRMAN: The only reason I ask is because you have it here and it is a pretty broad statement.

MR. MOISLEY: Well, we understand, of course, now in certain cases there are amounts contributed by the Federal Government for certain reasons and another payment by the Provincial Government we feel that in any program of this nature it should be established on this basis.

THE CHAIRMAN: That would be for what purpose? What is your basic idea? Are you thinking of a tax-supported program or a premium program?

MR. MOISLEY: Shall we say a combination of both?

THE CHAIRMAN: Number 7 has a tax-supported implication.

MR. MOISLEY: A tax-supported program for those priorities which we set out previously and a contributory one for those who can contribute.

COMMISSIONER BALTZAN: Touching upon the same subject in connection with the deterrent factor, you





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...the Commission ... the ... of ... and ... between ... and ... -- we need not be ... what have you in mind ...

... that is pretty

... pretty broad question.

... The Chairman: The only reason I ask

... is a pretty broad

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Moisley 10682

are applying that to prescribed drugs?

MR. MOISLEY: Yes, sir.

COMMISSIONER BALTZAN: I just want to get that clear on how that applies. If the prescription is given it is given because it is necessary and if it is not necessary it is a foolish kind of prescription. Now, when that prescription is given and it is necessary where does the deterrent element come in? It is given to be taken so often for so long, where does the extra charge limit or reduce the utilization if it is still necessary repeating, it must be necessary if a prescription was written out for it.

MR. MOISLEY: Well, could I answer this in this manner: In our experience of practising pharmacists we sometimes run across prescriptions which may be given because the patient requests them. Now, naturally we all realize it is the physician's responsibility to determine that factor before giving the prescription but we believe, and it has been experienced in plans of which we have knowledge, that immediately these prescription drugs are placed on a basis where they are easily procurable the costs go up. The more prescriptions issued the more patients using the plan and that is just what happens.

COMMISSIONER BALTZAN: It still does not stand right with me. Assuming, as I have said, and I want to repeat that it is necessary and if it is not necessary he does not get the prescription; if he gets it and it is not necessary the deterrent factor should go on the physician rather than the recipient.







Moisley 10683

MR. MOISLEY: Well, I say again that is part of the physician's responsibility, he should be assured that the prescription is necessary.

THE CHAIRMAN: You will have to get the detail-men working a little harder.

COMMISSIONER BALTZAN: I will still be thinking about that. I still cannot see how it applies when both things are equal, one, if it is found necessary and it is required and received through an authority who understand the need for it, now, after that I do not know where the utilization comes in.

MR. JESSUP: My understanding of that deterrent factor is that many items are sold over the counter. We will say, for instance, a couple of dozen aspirin, it does not cost very much, but if it is free, they would come to the doctor and get a prescription for it, otherwise they can buy it themselves. This is where the deterrent factor comes in, if they had to get a prescription for it they would think twice.

COMMISSIONER BALTZAN: You condition it, you mean the use, for making use of a commodity that they would have to pay for but by some arrangement of prepayment could be obtained free they would go and get a prescription?

MR. JESSUP : That is my understanding of the situation.

COMMISSIONER BALTZAN: So the other thing obtains that the one that has actually prescribed the deterrent factor does not particularly minimize the use of it.







Jessup 10684

MR. JESSUP: No.

COMMISSIONER BALTZAN: Are there many other instances comparable to aspirin that you used as an example where they go to a physician for a prescription, things that they can obtain over the counter?

MR. JESSUP: Quite a number of items that cost not too much that they buy over the counter and the deterrent factor might lessen their tendency to get a prescription.

THE CHAIRMAN: Let us get back on the rails. Are you talking about a plan that is going to cover anything but prescription drugs?

MR. JESSUP: It would be a prescription drug if the doctor prescribed it.

THE CHAIRMAN: Your program is not designed to cover anything but prescription drugs, is it?

MR. JESSUP: That is right.

COMMISSIONER BALTZAN: Just one other point. We had this occur before and you called attention on Page 12 to physicians' clinics and you say that many of these medications are dispensed by unqualified persons, a situation which the College believes the Commission will agree is fraught with danger to the public and should certainly not be allowed under any circumstances. Question number one: Under your existing Act, can anyone who is not qualified serve as a dispenser of goods and a compounder of drugs?

MR. MOISLEY: In clinics, yes, we have no control over the operation of a clinic by a group of medical practitioners.



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Other factors are taken into account in making the decision.

in a case where they are to a physician for a prescription.

tion, that is, that they are not over the counter.

It is noted that a number of items

that cost not too much that they buy over the counter.

The difference between the two is that the latter is

a prescription.

The question is whether or not it is

in the case of a person that is going to

be a person that is over the counter.

It is noted that it would be a prescription for

the person that is over the counter.

The question is whether or not

is assigned to cover anything but prescription drugs, is it?

It is noted that it is not

prescription drugs, but it is not

not, but it is not, but it is not

on the other hand, it is not

of these persons, and it is not

a prescription drug, but it is not

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It is noted that it is not

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Moisley 10685

COMMISSIONER BALTZAN: Has the Act any control? I do not know your Act?

MR. MOISLEY: In the interpretation of the Act, perhaps Mr. Isbister can answer this.

MR. ISBISTER: I think that the answer to this is that the Act specifically excepts, takes out from this Pharmacy Act -- may I read from Section 2, Sub-section J:

"Nothing in this Act affects or interferes with the compounding, dispensing or supplying of poisons or drugs in any hospital or institution approved or licensed under any general or special Act."

Strangely enough...

COMMISSIONER BALTZAN: Being a layman, would you tell me what that means?

MR. ISBISTER: In a pharmacy or a doctor's office authorized people are required to deal with these drugs. In a hospital in this Province such is not the case, a layman can be in the pharmacy or dispensary and compound or dispense.

COMMISSIONER BALTZAN: And the same thing in a medical clinic?

MR. ISBISTER: No, legally no.

COMMISSIONER BALTZAN: To what extent in this Province is the element of dispensing on the part of physicians? To what extent does that prevail?

MR. MOISLEY: In certain areas of the Province it prevails to a large extent and in Metro Toronto it prevails where pharmaceutical services are





COMMISSIONER BARTMAN: Has the Act any

controls? I do not know your Act?

MR. MOSELEY: Is the interpretation of

the-section?

Nothing in this Act affects or interferes  
with the compounding, dispensing or supplying  
of tablets or drugs in any hospital or  
institution approved or licensed under any

ordinance enough...

COMMISSIONER BARTMAN: Being a lawyer,

would you tell me what that means?

MR. MOSELEY: In a pharmacy or a

doctor's office authorized people are required to deal  
with these things. In a hospital in this Province and in  
not the case, a lawyer can be in the pharmacy or dispensary  
and compound the dispensary.

COMMISSIONER BARTMAN: And the same

thing in a medical clinic.

MR. MOSELEY: No, legally no.

COMMISSIONER BARTMAN: To what extent

is this Province is the extent of dispensing on the part

of the Province? To what extent does that prevail?

MR. MOSELEY: In certain areas of the

Province it prevails to a large extent and in certain

cases to it, certain pharmaceutical services are



Moisley 10686

readily available. There are many doctors, individuals two or three doctors in a small office ---

COMMISSIONER BALTZAN: An extended pharmacy, an extended service well supplied, etcetera.

MR. MOISLEY: Yes, sir.

COMMISSIONER BALTZAN: And what happens when the individual wants a repeat of that prescription, must he return to that same place?

MR. MOISLEY: Yes.

COMMISSIONER BALTZAN: Could he get a copy of the prescription and take it elsewhere?

MR. MOISLEY: We are not in the position to state that. We know nothing of what would happen in a case like that if a patient requested a copy in order to take it to a drugstore or some other place.

COMMISSIONER BALTZAN: One other thing, is the patient compelled to receive the drug from the physician who writes the prescription or may he take that prescription and go another place? Is it sort of a compulsory compound affair?

MR. MOISLEY: No.

COMMISSIONER BALTZAN: I am being very serious, I think we are both thinking alike, but I just want to hear what actually takes place.

MR. MOISLEY: Well, not to our knowledge, there is no endeavour to force anyone to take anything anywhere.

COMMISSIONER BALTZAN: To what?

MR. MOISLEY: There is no endeavour to force anyone to take anything anywhere, not to our knowledge.



mostly a matter of time. I have the necessary factors, and I have

two or three copies in a small office -

DR. WILLIAMS: Are you sure?

pharmacist, an extended service well supplied, etcetera.

MR. WILLIAMS: Yes, sir.

when the individual wants a report of that prescription,

will be returned to that same office.

DR. WILLIAMS: Could he get a

copy of the prescription and take it elsewhere?

MR. WILLIAMS: He can not in the

position to state that. He knows nothing of what would

happen in a case like that if a patient requested a copy

in order to take it to a druggist or some other place.

is the patient compelled to receive the drug from the

physician who writes the prescription or may he take that

prescription and go to another place? Is it some of a

community corporation?

MR. WILLIAMS: No.

DR. WILLIAMS: I am asking you.

DR. WILLIAMS: I think we are going to have a look, and I guess

will be able to find out what is going on.

MR. WILLIAMS: No, I am not sure.

there is no reason to believe anyone to have anything

to say.

DR. WILLIAMS: I am not sure.

DR. WILLIAMS: I am not sure.

DR. WILLIAMS: I am not sure.



Moisley 10687

COMMISSIONER BALTZAN: What I am trying to say is this, once the patient requires that medicine he automatically obtains it from that group or that individual doctor?

MR. MOISLEY: Yes.

COMMISSIONER BALTZAN: Do you know if the physician writes out the prescription for the drug, or just simply goes to the shelf and hands out the medicine or the pills?

MR. MOISLEY: In many cases that we know of the physician writes a prescription and it is taken down the hall to another little office and somebody fills the prescription.

COMMISSIONER BALTZAN: But he is at liberty to take it across the street?

MR. MOISLEY: No, I would not say so in this case.

COMMISSIONER BALTZAN: In the same connection, you say in Paragraph 39 for the first time that certain societies engage in a certain practice and then I see in the last half of the paragraph that a wholesale buying takes place by organizations and who hands these drugs out?

MR. MOISLEY: Unqualified people.

COMMISSIONER BALTZAN: Somebody may buy up a group of drugs for its members and then go in and ask for a headache pill and a stomach pill and so they get it that way?

MR. MOISLEY: That happens.

COMMISSIONER BALTZAN: Without diagnosis?







Moisley 10688

THE CHAIRMAN: This is all very interesting, but completely extraneous to the ambit of this Commission's inquiry. These are purely Provincial matters, are they not?

MR. MOISLEY: I am afraid so, sir.

COMMISSIONER BALTZAN: I just wanted to be informed. Thank you very much.

MR. ISBISTER: If I may say so, I think that, I think that there is no quarrel at all with the statement that these are Provincial matters, but the position of the College is if there is to be a health plan of some sort and if drugs are to be supplied through a health plan they ought to be supplied through qualified people.

THE CHAIRMAN: That phase of it no one was taking objection to, that is a proper recommendation, but in getting into the details ---

MR. ISBISTER: I wonder if I might make one more observation at this moment? You mentioned prescription drugs; now, in this jurisdiction under the Pharmacy Act there is a schedule of drugs which are known as prescription drugs in that one cannot obtain them unless one has a prescription. Of course, there are, as the Commission knows, countless other drugs which are not on that schedule which may be bought over the counter, but which may very well be prescribed by the physician and in that sense they are a prescription drug but not in the sense that you must have a prescription to get them.

THE CHAIRMAN: So there may be no misunderstanding, I am putting it to you, are you suggesting



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ing, but completely extraneous to the ambit of this

particular, and they need

MR. HOLMES: I am afraid so, sir.

MR. ALMOND: I just wanted

to be informed. Thank you very much.

MR. ALMOND: If I may say so, I

think that there is no quarrel at all with

the statement that these are provincial matters, but the

position of the college is that there is to be a health

plan of some sort and it seems to be supplied through

a health plan they ought to be supplied through qualified

people.

THE CHAIRMAN: That phrase of it no one

was talking of, and so, that is a proper recommendation.

--- in getting into the details ---

MR. ALMOND: I wonder if I might

have one more question at this moment. You mentioned

provincial matters, and in this jurisdiction under the

provision for the health plan, is it correct that the known

as provincial matters that the health plan should contain them

unless there is a reservation. Of course, there are, as

the Commission report, some other things which are not

on that committee which may be brought over the country,

but which may very well be prescribed by the physician

and in that sense they are a prescription and not in

the sense that you have had a prescription to get them.

MR. ALMOND: So there may be no

misunderstanding, I am putting it to you, are you suggesting



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Isbister 10689

that in that field there should be under the benefits of  
a comprehensive health service that a person without a  
doctor's prescription may go then to get a bottle of pills,  
that is an item to be covered?





January 1901

that in the first place, should be under the benefit of  
a compulsory, or rather, to be a person without a  
doctor a person of an age to get a bottle of pills  
that is in fact to be a person



Isbister

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MR. ISBISTER: No, sir. I suggest while it may not be a prescription drug in the sense it requires a prescription, if it is prescribed by the physician I presume it would come within the scope of your plan.

THE CHAIRMAN: Yes.

COMMISSIONER FIRESTONE: Mr. Moisley, in paragraph 5 on page 23, you express the view you would be in favour of patients contributing a nominal amount to each prescription under a prepaid drug plan. What would be your definition of a nominal amount? Would it be, say, \$1 a prescription, 50¢ a prescription?

MR. MOISLEY: In plans we know of, sir, it runs from 35¢ upwards. I think a nominal amount is an amount that most people can afford to pay without stretching the pocket. Wouldn't that take care of it?

COMMISSIONER FIRESTONE: We would appreciate some guidance from the College as you know something of the kind of drugs people buy and the kind of price they pay.

What would you consider a nominal amount in relation to what is the actual price at the present time? Would this 50¢ to \$1 be still a nominal amount in the definition as used by you?

MR. MOISLEY: I would say so, yes sir. Council discussed it and they thought that 50¢ to \$1 would be considered a nominal amount.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Thank you, Mr. Moisley



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TORONTO, ONTARIO

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and gentlemen. We are going to be hearing from other organizations interested in pharmacy and pharmaceutical practices. Please feel perfectly free to remain and if, in the discussion, something comes up that may affect the College and you wish to interpolate an explanation, feel free to do so.

MR. MOISLEY: Thank you very much.





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practices. Please feel perfectly free to remain and  
if, in the discussion, something comes up that may  
affect the College and you wish to interpolate an  
explanation, feel free to do so.  
MR. MOTLEY: Thank you very much.



10692

THE SECRETARY: The next submission is the Canadian Foundation for the Advancement of Pharmacy. The Exhibit will be known as 294. Also, as Exhibit 294A there is an exhibit which has been sent to me which contains the teaching manual, Careers in Canadian Pharmacy and also a film.

--- EXHIBIT NO. 294: Submission of the Canadian Foundation for the Advancement of Pharmacy.

--- EXHIBIT NO. 294A: "Teaching Manual - Careers in Canadian Pharmacy" and film strip.

SUBMISSION OF THE CANADIAN FOUNDATION

FOR THE ADVANCEMENT OF PHARMACY

Appearances: Prof. G.C. Walker  
Dean Roger Larose

PROF. WALKER: May I introduce myself, sir, and also with me here is Dean Roger Larose of the Faculty of Pharmacy, University of Montreal and we also have Mr. John R. Kennedy, one of the original founders of the Canadian Foundation for the Advancement of Pharmacy.

I am here by virtue of being Vice-President of the Committee on Pharmaceutical Education and Research. The Chairman of this Committee is Dean W.C. MacAulay of the University of Saskatchewan, College of Pharmacy.

(1) This submission is presented by the Canadian Foundation for the Advancement of Pharmacy in order to provide the Commission members with



THE SECRETARY: The next submission

is the Canadian Foundation for the Advancement of Pharmacy. The Exhibit will be known as 1944. Also, as Exhibit 1944 there is an exhibit which has been sent to me which contains the teaching manual, lessons in Canadian Pharmacy and also a film.

--- EXHIBIT NO. 1944: Submission of the Canadian Foundation for the Advancement of Pharmacy.

--- EXHIBIT NO. 1944: "Teaching Manual - Careers in Canadian Pharmacy" and film strip.

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FOR THE ADVANCEMENT OF PHARMACY

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Walker 10693

information relative to the formation, organization, development and function of the Canadian Foundation for the Advancement of Pharmacy (hereinafter referred to as the Foundation).

(2) The Foundation was created as a result of a need for an assistance organization for pharmacy in Canada. The need became acutely evident during the period of rapid expansion and development immediately following the Second World War when it was recognized by pharmacists and organizations of pharmacists.

(3) Preliminary planning and exploration resulted in the election of a provisional Board of Directors, in May of 1945, and the granting of a Federal Charter on September 4 of the same year. The Foundation was granted recognition as a charitable organization.

(4) It is an assistance organization which sets no policies with respect to the practice of pharmacy in any sense, broad or restrictive; regional or national; professional or commercial; retail, hospital or industrial. The object of the Foundation is to solicit and to receive donations and legacies, and to disburse these funds (or the interest thereon) for the benefit of all branches of pharmacy in Canada with particular emphasis on pharmaceutical education.

(5) Membership, which may be Honorary, Active or Associate, is open to every person, corporation and institution having, directly or indirectly, an interest in the welfare of pharmacy in Canada.





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(5) Membership, which may be honorary, active or associate, is open to every person, corporate or individual, residing in Canada, and is the interest in the welfare of pharmacy in Canada.



Walker

10694

(6) A Board of twenty-five Directors determines the policies of the Foundation. A serious attempt is made to have all types of pharmaceutical organizations represented.

(7) The committees of the Foundation are as follows: Contributions, Extension Services, Finance, Loans, Pharmaceutical Education and Research, Professional Relations and Vocational Guidance. Committees make decisions on applications for grants-in-aid in accordance with the policy laid down by the Board.

(8) The Past Presidents' Advisory Council is composed of the Past Presidents of the Foundation and its members serve in an advisory capacity.

(9) The Practising Pharmacists' Advisory Council is composed of retail pharmacists and was established by the Foundation to provide information and assistance to the retail pharmacist.

(10) From its inception in September, 1945, until May 31, 1961, the Foundation has granted funds for many purposes, the most important of which are shown below. (The figures in brackets give the total amount expended for each of the purposes indicated.)

(a) To Schools of Pharmacy

(i) Teaching Fellowships, generally  
\$1200 each (\$19,630)

(ii) Research Grants, generally  
\$500 to \$600 each (\$28,475)

(iii) Canadian Conference of Pharmaceutical Faculties (C.C.P.F.) - the



(6) A kind of twenty-five dollar  
determines the policies of the Foundation. A serious  
attempt is made to have all these of a substantial  
organizational representation.

(7) The committee of the Foundation  
are as follows: Control, Finance, Extension Services,

Professional Relations and Vocational Guidance.  
Committees make decisions on applications for grants-  
and in accordance with the policy laid down by the  
Board.

(8) The First President's Advisory

Council is composed of the First Presidents of the  
Foundation and its members serve in an advisory capacity.

Advisory Council is composed of retail pharmacists and  
was established by the Foundation to provide information  
and assistance to the retail pharmacist.

(9) From its inception in September,  
1945, until May 31, 1961, the Foundation has granted  
funds for many purposes, the most important of which  
are shown below. (The figures in brackets give the  
total amount expended for each of the purposes indicated.)

(a) The Council of Pharmacy

(1) Research Fellowships, generally

\$1,000 each (\$10,000)

\$500 to \$200 each (\$25,000)

(2) Research Fellowships of Junior

and Senior Technicians (C.P.T.) - the



Walker

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C.C.P.F. has as its membership the schools of pharmacy in Canada. Meetings of the Conference are held annually at the time and place of the annual meeting of the Canadian Pharmaceutical Association. Assistance is provided by the Foundation to enable delegates and members to attend the annual meeting. In addition, the Foundation provides support for the C.C.P.F. Bulletin which is published quarterly and provides a medium for the dissemination of information on matters pertaining to pharmaceutical education (\$14,178.14).

(iv) Teachers' Seminars - Assistance to staff members attending United States summer seminars at universities in the United States - varying amounts (\$3,005.76).

(v) Canadian Conference on Pharmaceutical Research - the research conference provides an opportunity for researchers in various aspects of pharmaceutical endeavour to meet each year for the presentation of papers. The conference is held annually, if possible, and at the time and place of the meeting of the





... as its responsibility  
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 the annual meeting of the Canadian  
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attend the annual meeting. In  
 addition, the Foundation provides  
 support for the C.P.P.A. Bulletin  
 which is published quarterly and  
 provides a medium for the dissemina-  
 tion of information on various par-  
 taining to pharmaceutical education

(iv) Teachers' Seminars - assistance  
 to staff members attending United  
 States and in seminars at various  
 times in the United States - varying  
 amounts (\$2,000-700).

(v) Canadian Conference on Pharmaceu-  
 tical Research - two research  
 conferences providing an opportunity  
 for researchers in various aspects  
 of pharmaceutical endeavour to meet  
 each year for the presentation of  
 papers. The conference is held  
 annually, if possible, and at the  
 time and place of the meeting of the



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Canadian Pharmaceutical Association,  
and is sponsored jointly by the  
Foundation and the C.C.P.F. (\$321.80).

(b) To Students

(i) Admission Bursaries - \$250  
(\$12,000).

(ii) Undergraduate Scholarships -  
\$100 for every fifty students (or  
fraction thereof) enrolled in the  
pre-graduation years in the school  
of pharmacy in Canada - varying  
amounts (\$4,000).

(iii) Loans to Undergraduate and  
Graduate Students - interest free  
(\$53,470).

(iv) Graduate Study Fellowships,  
generally \$375 to \$750 each (\$49,750).

(v) Graduate Fellowships in  
Hospital Pharmacy - \$750 each (\$3,000).

(c) To Furnish Annual Awards for  
Undergraduate Research

(i) The E.L. Woods Memorial Prize  
in Pharmacy for the best laboratory  
research thesis by an undergraduate  
student at any school of pharmacy  
in Canada, consisting of a gold  
medal, a certificate of merit, \$100  
in cash, and transportation to and  
from the site of the annual meeting  
of the Canadian Pharmaceutical Association



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and is sponsored jointly by the  
Foundation and the C.C.P.A. (1932, 80).

(a) Grants

(i) Admission bursaries - \$100

(\$10,000).

(ii) Postgraduate scholarships -

\$100 for every fifty students (or

fraction thereof) enrolled in the

pre-graduate years in the school

of pharmacy in Canada - varying

amounts (\$1,000).

(iii) Loans to Undergraduate and

Graduate students - interest free

(\$50,000).

(iv) Graduate Study Fellowships,

generally \$250 to \$750 each (\$25,000).

(v) Graduate Fellowships in

hospital pharmacy - \$250 each (\$25,000).

(b) To Fund a Award for

(1) The R.L. Wood Memorial Prize

is awarded for the best research

research thesis by an undergraduate

student at any school of pharmacy

in Canada, consisting of a gold

medal, a certificate of merit, \$100

in cash, and a recommendation to the

board of the school of pharmacy.

of the Canadian Pharmaceutical Association



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(\$3,048.70).

(ii) The Aubrey A. Brown Memorial  
Award for the best research thesis  
of the library, archives and/or  
survey type consisting of a certifi-  
cate of merit, gold medal, \$100 in  
cash, and transportation to and from  
the annual pharmaceutical convention  
in the province in which the winner  
resides.

(d) To Provide Funds for Vocational  
Guidance, Recruitment, Continuing  
Education and Professional Relations

(i) Vocational Guidance and Student  
Recruitment - the Foundation provides  
guidance aids to Canadian secondary  
schools and other interested groups in  
the form of Teaching Manuals and Film  
Strips, career posters, pamphlets  
and leaflets (in both the English  
and French languages); colour and  
sound films (\$15,608.93).

(ii) Refresher Courses and Extension  
Services - continuing education is  
a matter of prime importance in any  
profession and the Foundation endea-  
vours to assist financially (\$33,400).

(iii) Professional Relations - the  
Foundation participates in any  
activity in which pharmacy may serve





1953, 1954, 1955.

(iii) The Hon. A. Brown, Minister of Education

will be the main research officer

of the survey, archives and/or

survey type consisting of a certified

copy of the original, gold medal, 1953 in

the form of a certificate to and from

the annual international convention

in the province in which the survey

(d) To provide funds for the survey

Education and Research in the Province

(e) Voluntary Guidance and Student

Recruitment - the Foundation provides

guidance and to Canadian secondary

schools and other interested groups in

the form of Teaching Materials and Film

and facilities (in both the English

and French languages); colour and

(f) Refresher Courses and Extension

services - continuing education in

a matter of public importance in any

education and the Foundation enters

into a special relationship (1953, 1954)

with the Provincial Relations - the

Foundation participates in the

activities in which partnership may serve



Walker

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in matters concerning the health of  
the nation.

(11) The future will see the need for  
greater assistance to pharmacy and pharmaceutical  
education. This will necessitate a markedly increased  
and expanded effort on the part of the Foundation to  
collect funds and to disburse them to the best advan-  
tage. The Canadian Foundation for the Advancement of  
Pharmacy has given very real assistance to Canadian  
pharmacy over the past sixteen years, and will continue  
to serve the best interests of pharmacy in the years  
ahead.

#### SUMMARY OF ASSISTANCE PROGRAMS

40. The foregoing expenditures  
(together with a few miscellaneous items not specified)  
show that the Foundation has, in the period from  
September 1945 to May 1961, provided financial assis-  
tance amounting to \$218,466.52, which, together with  
loans in the amount of \$53,470, makes a total of  
\$271,936.52.

41. The expenditures referred to  
above are facts of a financial nature but they do not  
reveal what the work of the Foundation has actually  
meant to the various branches of pharmacy in terms of  
encouragement and incentive, organization and develop-  
ment, and better trained young men and women. It is  
difficult to put into words the many benefits, both  
tangible and intangible, accruing to Canadian pharmacy  
through the work of the Foundation.

42. In 1944 the seven schools of



Letter

in letters concerning the health of

the nation.

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greater assistance to pharmacy and pharmaceutical education. This will necessitate a markedly increased and expanded effort on the part of the Foundation to collect funds and to disburse them to the best advantage. The Canadian Foundation for the Advancement of Pharmacy has given very real assistance to Canadian pharmacy over the past sixteen years, and will continue to serve the best interests of pharmacy in the years

SUMMARY OF ASSISTANCE PROGRAM

40. The foregoing expenditures (together with a few miscellaneous items not specified) show that the Foundation has, in the period from September 1945 to May 1961, provided financial assistance amounting to \$218,466.52, which, together with loans in the amount of \$53,470, makes a total of

41. The expenditures referred to above are facts of a financial nature but they do not reveal what the work of the Foundation has actually meant to the various branches of pharmacy in terms of encouragement and incentive, organization and development, and better trained young men and women. It is difficult to put into words the many benefits, both tangible and intangible, accruing to Canadian pharmacy through the work of the Foundation.

42. In 1944 the seven schools of





Walker

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pharmacy in Canada had only ten full-time staff members. In 1961 there were eight schools of pharmacy with over 50 staff members, the majority of whom held advanced degrees. Many of these staff members had been aided by the Foundation. Courses in the schools of pharmacy had been lengthened and strengthened by means of the augmented and better-trained staffs.

43. From its inception up to May 31, 1961, some 57 graduates from pharmacy schools have been assisted towards advanced degrees by means of graduate study fellowships. All branches of the profession have benefited not only from the increased numbers of graduates but also from the higher education standards. While the Foundation has not been solely responsible for the expansion and implementation of these educational research and guidance programs, it is reasonable to suggest that without its help this development would never have been achieved in the same period of time.

#### THE FUTURE

44. Emphasis on the population explosion and the problems concomitant with this rapid increase are familiar to all of us, one of the most important considerations being that of education for and in the future.

45. The Foundation has aided Canadian pharmacy through a critical period in its development. Canadian pharmacy is now entering another such period where the demands in all areas will be increased. What has already been spent is a small amount in comparison to what will be needed. The Foundation will have to





pharmacy in Canada had only ten full-time staff members. In 1961 there were eight schools of pharmacy with over 80 staff members, the majority of whom held advanced degrees. Many of these staff members had been aided by the Foundation. Courses in the schools of pharmacy had been strengthened and strengthened by means of the suggested and better-trained staff.

43. From the inception up to May 31, 1961, some 57 graduates from pharmacy schools have been assisted towards advanced degrees by means of graduate study fellowships. All graduates of the profession have benefited not only from the increased number of graduates but also from the higher education standards. While the Foundation has not been solely responsible for the expansion and implementation of these educational research and guidance programs, it is reasonable to expect that with the help this development would never have been achieved in the same period of time.

THE FUTURE

44. Changes on the population explosion and the problems concomitant with this rapid increase are similar to that of us, one of the most important considerations being that of education for and in the future.

45. The Foundation has and will continue to play a significant role in its development. Canadian pharmacy is now entering another new period where the demand for and interest will be increased. It has already been said that a small amount of participation to what will be needed. The Foundation will have to



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2  
3 seek increased contributions, as well as other sources  
4 of revenue, and even with these it is anticipated that  
5 the need for funds will exceed the supply. The  
6 Canadian Foundation for the Advancement of Pharmacy  
7 welcomes the challenge of the future and will do every-  
8 thing in its power to aid pharmacy and pharmaceutical  
9 education in Canada.

10 Mr. Chairman, I think there is a place  
11 for such an independent organization in Canada. The  
12 Government has many requests for funds and grants, and  
13 rightly so, but there is a role for an organization  
14 such as this.

15 Each profession has a responsibility  
16 to support its membership and to provide assistance  
17 to young people at all times, if possible.

18 Personally, I feel that these men in  
19 the Foundation derive a great deal of pleasure from  
20 giving and promoting this type of organization. It is  
21 a feeling of satisfaction and accomplishment. Although,  
22 admittedly, the amounts are small, pitifully small in  
23 comparison to others we have heard today, it has  
24 provided real help to a number of young Canadians.  
25 It will continue to meet the challenge in the future  
26 in this direction. Thank you, Mr. Chairman.

27 THE CHAIRMAN: Thank you very much,  
28 Professor Walker and Dean Larose. I think one must  
29 be impressed with what has been done by the Foundation  
30 in the period from 1945 to 1961, as you have, money-wise,  
recapitulated in the last three pages of the document.

Perhaps the question that actually



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of revenue, not even which, here it is a stipulated that  
the need for this will be met in the long run.  
Canadian Foundation for the Advancement of Learning  
welcomes the challenge of the future and will do every-  
thing in its power to aid in many and various ways  
education in Canada.  
Mr. Chairman, I think there is a place  
for such an independent organization in Canada. The  
Government has many requests for funds and grants, and  
rightly so, but there is a role for an organization  
such as this.  
Each professor has a responsibility  
to support its research and to provide assistance  
in other fields at all times, in possible.  
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giving and receiving the best of organization. It is  
a feeling of satisfaction and accomplishment. Although,  
initially, the amounts are small, gradually small in  
comparison to others we have heard today, it has  
provided real help to a number of young Canadians.  
It will continue to meet the challenge in the future  
in this direction. Thank you, Mr. Chairman.  
Mr. Chairman, Thank you very much.  
Professor, you are not alone. I think one may  
be impressed with what has been done by the foundation  
in the past from 1945 to 1965, as you have mentioned,  
mentioned in the last three pages of the document.  
I think the foundation that actively



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comes to mind is where you get your funds; you don't get them from the Government, for which you almost merit a halo.

PROF. WALKER: They are raised by collections, not done by the Foundation, per se, but it is done by the Committee of Contribution that actually goes about the business of collecting these across Canada from the retail pharmacies and, in general, the industrial facet, wholesale and so forth.

The retail contribution on April 30th, the total received, retail, hospital, college, etc., \$11,000 and then from the more independent endowments and other funds, manufacturers embracing delayed cost priorities, pharmaceuticals, totalling \$15-and-a-half thousand, so the total collection would be \$34,000.

THE CHAIRMAN: If I understood your statement correctly, it is whatever may be done, whatever forms of projected plans for health services might emerge you want to be left alone to carry on your work; is that right?

PROF. WALKER: We would like to continue, sir, if we can.

DEAN LAROSE: I think we could do - this could be the pattern even if assistance were given by pharmacies, by government or organized groups.

THE CHAIRMAN: It might be the instrument through which it could be.

DEAN LAROSE: That is correct, yes.

COMMISSIONER FIRESTONE: Professor Walker, following up the question the Chairman raised,





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get them from the Government, for which you almost  
never ask.

MR. WALKER: They are raised by  
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general, the industrial sector, wholesale and so forth.  
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\$11,000 and then from the more independent endowments  
and other funds, manufacturing endowments, played cost  
priorities, pharmaceuticals, totaling \$15,000 and a  
thousand, so the total collection would be \$26,000.

MR. WALKER: I understand you  
state that correctly, it is whatever may be done, what-  
ever form of projected plans for health services  
might emerge you want to be left alone to carry on  
your work; is that right?

MR. WALKER: We would like to  
continue, sir, if we can.

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pharmacies, by government or organized groups.

MR. WALKER: It might be the instrument  
through which it could be.  
MR. WALKER: That is correct, yes.

MR. WALKER: Following up on the question the Chairman raised,



Walker

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you feel that there is a need to increase the number of graduate scholarships, fellowships and grants to both young men coming into the university as undergraduate as well as graduate students. Is there a need to increase the number of grants?

PROF. WALKER: Yes, there is, Dr. Firestone.

COMMISSIONER FIRESTONE: And the amounts for actual disposal are limited, and if you cannot expand the sums of money which you require from the sources you are relying on would you expect the Federal Government might make available grants to students, for graduate students teaching at university in the field of pharmacy?

PROF. WALKER: I certainly know funds will have to come. Dr. Firestone, definitely we hope, of course, wherever we get the funds we will get them and use them to the best advantage.

COMMISSIONER FIRESTONE: Have you any suggestions, any concrete suggestions, as to how many scholarships and the amount you would recommend the Federal Government makes available to assist in the training program of the large number of pharmacists that you seem to visualize for the next five or ten years?

PROF. WALKER: I haven't, sir, at the moment. I believe the Canadian Association of Pharmaceutical Faculties in their brief will have something to say about that. Perhaps Dean Larose has.







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4 COMMISSIONER GIRARD: Have you had  
5 large numbers of demands for bursaries that you are  
6 unable to fulfil?

7 PROFESSOR WALKER: No Miss Girard,  
8 I would have to say that we are unable to fill them all,  
9 yes. We have done pretty well, and sometimes we have  
10 squeezed it by curtailing and cutting back a bit and  
11 giving some more ---

12 COMMISSIONER GIRARD: So if you had  
13 more money you would increase the bursaries, rather than  
14 give more bursaries, if there is not such an amount?

15 DEAN LAROSE: No, I don't think so.  
16 If you talk about graduate scholarships rather than  
17 bursaries, we are limited by the number we can get.  
18 There is a tremendous competition between various fields  
19 of pharmacy, and in order to train a graduate pharmacist  
20 to go for instance into research or teaching or hospital  
21 pharmacy, we have to help him, and we certainly don't  
22 help all those that are required. We only try to interest  
23 those for whom we have the money, so the fact that  
24 we have been able to meet the immediate requirements  
25 for money does not mean that we have been able to meet  
26 the requirements for the profession, or for the practise  
27 of pharmacy.

28 COMMISSIONER STRACHAN: I would be  
29 interested to have some further information regarding  
30 the loans to graduate and under-graduate students,  
interest-free. What is your experience in the repayment  
of these loans, and what are the terms under which you  
expect repayment?





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COMMISSIONER OF EDUCATION: Have you had

large numbers of demands for bursaries that you are

unable to fulfill?

I would have to say that we are unable to fill them all, yes. We have some pretty well, and sometimes we have answered it by curtailing and cutting back a bit and giving some more ---

COMMISSIONER OF EDUCATION: So if you had

more money you would increase the bursaries, rather than give more bursaries, if there is not such an amount? DEAN LARSON: No, I don't think so.

If you talk about graduate scholarships rather than bursaries, we are limited by the number we can get. There is a tremendous competition between various fields of pharmacy, and in order to train a graduate pharmacist to go for instance into research or teaching or hospital pharmacy, we have to help him, and we certainly don't help all those that are required. We only try to interest those for whom we have the money, so the fact that we have been able to meet the immediate requirements for money does not mean that we have been able to meet the requirements for the profession, or for the practice of pharmacy.

COMMISSIONER OF EDUCATION: I would be

interested to have some further information regarding the loans to graduate and under-graduate students interest-free. What is your experience in the repayment of these loans, and what are the terms under which you expect repayment?



Walker

PROFESSOR WALKER: Dr. Strachan, as far as I know we have never had a single case of non-repayment. There was one, I believe, and that was eventually taken care of, and right now we don't have any like that.

COMMISSIONER STRACHAN: What about the average amount to each student?

PROFESSOR WALKER: It varies sir. It may vary from three to five hundred dollars, and more has been granted. \$750.00 in cases, but it generally runs around \$500.00.

COMMISSIONER STRACHAN: When is the student expected to start repayment?

DEAN LAROSE: About one year after he has completed his studies.

COMMISSIONER STRACHAN: And when is it expected that he would terminate the payments? Is it left to him entirely?

DEAN LAROSE: We make it convenient for him. We want the money back. We are not in a hurry but we make individual arrangements with him.

THE CHAIRMAN: So that you can lend it out again?

DEAN LAROSE: Yes.

COMMISSIONER STRACHAN: Regarding the E.A. Woods Memorial Prize and the R.A. Brown Memorial Warrant, do these sums come from your current collections?

PROFESSOR WALKER: Yes, they come from our collections each year Dr. Strachan.

THE CHAIRMAN: Thank you very much Mr.



PROFESSOR WALKER: Mr. Stedman, as

far as I know we have never had a single case of non-  
payment. There was one, I believe, and that was  
eventually taken care of, and right now we don't have  
any like that.

COMMISSIONER STEDMAN: What about

the average amount to each student?

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now vary from three to five hundred dollars, and more  
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THE CHAIRMAN: So that you can lend

COMMISSIONER STEDMAN: Regarding the

F.A. Woods Memorial Prize and the F.A. Woods Memorial  
Prize, do these come from your current collections?  
PROFESSOR WALKER: Yes, they come

THE CHAIRMAN: Thank you very much Mr.





Walker

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Walker and Dean Larose.

THE SECRETARY: Mr. Chairman, the next submission is the Canadian Society of Hospital Pharmacists, which will be exhibit 295. Mr. Stewart will introduce his group.

---EXHIBIT NO. 295: Submission of the Canadian Society of Hospital Pharmacists.

SUBMISSION OF  
THE CANADIAN SOCIETY OF HOSPITAL PHARMACISTS

APPEARANCES: Mr. T. McNab  
Mr. D. J. Stewart  
Prof. Isabel Stauffer  
Miss Mary Gannon

MR. McNAB: Mr. Chairman, my name is McNab and I am the president of the Canadian Society of Hospital Pharmacists. On the extreme right is Miss Mary Gannon, chief pharmacist of the Princess Margaret Hospital in Toronto. Next to her is Professor Isabel Stauffer of the Faculty of Pharmacy of the University of Toronto and on my right is Mr. D. J. Stewart chief pharmacist of the Royal Victoria Hospital in Montreal. Mr. Stewart will present our summary of the submission.

MR. STEWART: Mr. Chairman and Members of the Commission: The summary of the submission presented by the Canadian Society of Hospital Pharmacists to the Royal Commission of Health Services.

1. This brief is respectfully presented by the Canadian Society of Hospital Pharmacists, a





Willis and Jean Larose.

THE SECRETARY: Mr. Chairman, the

next nomination is the Canadian Society of Hospital  
Pharmacists, which will be exhibit 285. Mr. Stewart  
will introduce his group.

Submission of the  
Canadian Society of  
Hospital Pharmacists.

PRESENTATION OF

THE CANADIAN SOCIETY OF HOSPITAL PHARMACISTS

Mr. D. J. Stewart  
Prof. Isabel Gannon  
Miss Mary Gannon

Mr. McVAB: Mr. Chairman, my name is

McVab and I am the president of the Canadian Society of  
Hospital Pharmacists. On the extreme right is Miss Mary

Gannon, chief pharmacist of the Princess Margaret  
Hospital in Toronto. Next to her is Professor Isabel  
Stewart of the Faculty of Pharmacy of the University  
of Toronto and on my right is Mr. D. J. Stewart chief  
pharmacist of the Royal Victoria Hospital in Montreal.  
Mr. Stewart will present our summary of the submission.

Mr. Stewart: Mr. Chairman and Members

of the Commission: The summary of the submission

presented by the Canadian Society of Hospital Pharmacists  
to the Royal Commission of Health Services.

This is all respectfully presented

by the Canadian Society of Hospital Pharmacists, a



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4 voluntary national organization of pharmacists engaged  
5 in the practice of pharmacy in Canadian hospitals.  
6 Measures which pertain to two important health services,  
7 pharmacy and hospitals, are of major interest to  
8 hospital pharmacists. One of the important functions  
9 of the pharmacy department in a hospital is the  
10 purchase, distribution and control of all drugs and  
11 chemicals used for the treatment of patients. The  
12 members of this Society believe that the standards  
13 established with respect to medication for hospital  
14 patients play a significant role in ensuring the best  
15 possible health care for all Canadians. It is for  
16 this reason that the Canadian Society of Hospital  
17 Pharmacists wishes to express its views on those areas  
18 which fall within its sphere of competence and present  
19 such recommendations as may appear suitable to the  
20 Royal Commission on Health Services.

21 2. The pharmacy is an essential facility  
22 of a modern hospital. It is the function of the  
23 hospital pharmacist to procure store, distribute and  
24 control all drugs, chemicals and diagnostic agents used  
25 in the hospital in the treatment of patients. To provide  
26 this service he must assume a high level of professional  
27 responsibility and be employed full-time.

28 3. In all hospitals, the supervision of  
29 dispensing and other pharmaceutical services by a  
30 licensed pharmacist is essential for patient safety.  
However, it would be impractical to suggest that every  
hospital be required to employ a pharmacist full-time.  
In hospitals of 74 beds or less, the Canadian Society of



voluntary national organization of pharmacists engaged in the practice of pharmacy in Canadian hospitals. Measures which pertain to two important health services, pharmacy and hospitals, are of major interest to hospital pharmacists. One of the important functions of the pharmacy department in a hospital is the purchase, distribution and control of all drugs and chemicals used for the treatment of patients. The members of this society believe that the standards established with respect to medication for hospital patients play a significant role in ensuring the best possible health care for all Canadians. It is for this reason that the Canadian Society of Hospital Pharmacists wishes to express its views on those areas which fall within its sphere of competence and present such recommendations as may appear suitable to the Royal Commission on Health Services.

2. The pharmacy is an essential facility of a modern hospital. It is the function of the hospital pharmacist to procure stores, distribute and control all drugs, chemicals and diagnostic agents used in the hospital in the treatment of patients. To provide this service he must assume a high level of professional responsibility and be employed full-time.

3. In all hospitals, the supervision of dispensing and other pharmaceutical services by a licensed pharmacist is essential for patient safety. However, it would be impractical to expect that every hospital be required to employ a pharmacist full-time. In hospitals of 20 beds or less, the Canadian Society of





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Pharmacists recommends that:

(i) Two or more hospitals share a pharmacist on a part-time basis;

(ii) The services of a retail pharmacist be obtained on a part-time basis;

(iii) The hospital employ a pharmacist who could combine pharmaceutical functions with other duties, such as purchasing or other administrative duties; or

(iv) A consulting service in pharmacy and a limited pharmaceutical supply service be provided through Regional Hospital Councils.

In all hospitals of 75 beds or more, the Canadian Society of Hospital Pharmacists recommends that a licensed pharmacist be employed full-time and that an additional licensed pharmacist be appointed for each additional 100 beds or major portion thereof. It is further recommended that the continued payment of federal grants for hospital operations be contingent upon the maintenance of the above standards of pharmacy supervision.

4. The Canadian Society of Hospital Pharmacists wishes to bring to the attention of the Commission the following deficiencies in the present methods of providing drugs and pharmaceutical services in Canadian hospitals.

(i) Hospitals in which there is no supervision of the pharmaceutical service by a legally qualified pharmacist;

(ii) Hospitals in which there does not





Pharmaceuticals Division

(1) The hospital pharmacist should

(2) The services of a hospital pharmacist

be provided on a part-time basis;

(3) The hospital employ a pharmacist

who would combine pharmaceutical functions with other

duties, such as purchasing or other administrative

(4) A consulting service is necessary

and a limited pharmaceutical service is provided

through National Hospital Pharmacists

In all hospitals of a base or more,

the American Society of Hospital Pharmacists recommends

that a licensed pharmacist be employed full-time and

that an additional licensed pharmacist be appointed for

each additional 100 beds or major portion thereof. It

is further recommended that the continued payment of

such salaries for hospital operations be contingent

upon the maintenance of the above standards of pharmacy

The American Society of Hospital

Pharmacists wishes to bring to the attention of the

boards of the following organizations in the present

methods of providing drugs and pharmaceutical services

in hospital practice

in which there is no

provision of the pharmaceutical services by a hospital

pharmacist;

(5) Hospitals in which there is no



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appear to be a sufficient number of pharmacists to staff the department properly in proportion to the workload;

(iii) Hospitals which do not maintain an active pharmacy and therapeutics committee of the medical staff;

(iv) Hospitals which do not have a formulary or one which is kept up-to-date;

(v) Hospitals in which inadequate floorspace is provided for the pharmacy department;

(vi) Provincial Pharmacy Acts which permit drugs and medicinal preparations in hospitals to be compounded and dispensed by unqualified and unlicensed personnel.

Suggestions for improvements under points (i) and (ii) are covered in the preceding recommendation in paragraph 3 of this summary.

5. In general, with respect to improvements to remedy these deficiencies, the Canadian Society of Hospital Pharmacists suggests that the Minimum Standard for Hospital Pharmacy in Canada is applicable to all types of hospitals and furnishes a guide in the establishment, development and implementation of pharmaceutical service. The Society, therefore, recommends that these standards be adopted and used in an appropriate manner by all agencies engaged in the evaluation and implementation of pharmaceutical services in hospitals in Canada.

6. Specifically, with respect to the Pharmacy and Therapeutics Committee, the Canadian Society of Hospital Pharmacists recommends that, in order to



appear to be a sufficient number of pharmacists to  
 and the department properly in proportion to the

(iii) Hospitals which do not maintain

an active pharmacy and therapeutics committee of the  
 medical staff:

(iv) Hospitals which do not have a

formulary or one which is kept up-to-date;

(v) Hospitals in which inadequate

floor space is provided for the pharmacy department;

(vi) Provincial Pharmacy Acts which

limit sales and medicinal preparations in hospitals to

be compounded and dispensed by duly qualified and

qualified personnel.

Recommendations for improvements under

points (i) and (ii) are covered in the preceding

recommendation in paragraph 3 of this summary.

In general, with respect to improve-

ments to rectify these deficiencies, the Canadian Society

of Hospital Pharmacists suggests that the Minister

of Health for Hospital Pharmacy in Canada is applicable

to all types of hospitals and furnishes a guide in

the development, development and implementation

of pharmaceutical services. The Society, therefore,

recommends that these standards be adopted and used in

an appropriate manner by all agencies engaged in the

evaluation and implementation of pharmaceutical services

in hospitals in Canada.

Specifically, with respect to the

Pharmacy and Therapeutics Committee, the Canadian Society

of Hospital Pharmacists recommends that, in order to





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3  
4 assure the best possible health care for all Canadians  
5 when confined to hospital, an active Pharmacy and  
6 Therapeutics Committee be established in every Canadian  
7 hospital in accordance with the Minimum Standard for  
8 Hospital Pharmacy in Canada and that the pharmacist  
9 be a member of this committee.

10 7. The most important determining factor  
11 in the decision of any hospital formulary is the length  
12 of time required for the production of same. As a partial  
13 solution to this problem, the Canadian Society of  
14 Hospital Pharmacists recommends the following:

15 (i) That a Canadian Hospital  
16 Formulary Service, on a subscription basis, be established  
17 by pharmacists in Canada.

18 (ii) That, before establishing such  
19 a service, an extensive and exhaustive study be made  
20 of:

21 (a) the American Hospital Formulary  
22 Service,

23 (b) machine methods of reproduction for  
24 a hospital formulary, and

25 (c) other appropriate services, systems  
26 or methods available and acceptable.

27 (iii) That a federal grant, in the  
28 amount of \$20,000 be established to explore this project.

29 8. The members of the Canadian Society  
30 of Hospital Pharmacists believe that hospital administra-  
tors, hospital architects and hospital consultants are  
not fully cognizant of the need for the expansion of  
the facilities of the pharmacy department when the bed



and the local public health care for all Canadians  
when confined to hospital, an active pharmacy and  
The Canadian Committee is established in every Canadian  
hospital in accordance with the National Standard for  
Hospital Pharmacy in Canada and that the pharmacist  
be a member of this committee.

The most important determining factor  
in the decision of any hospital formulary is the safety  
of the required for the production of same. As a guide  
to this problem, the Canadian Society of  
Hospital Pharmacists recommends the following:

- (1) That a Canadian Hospital  
formulary be based, on a selection basis, be established  
by pharmacists in Canada.
- (2) That, before establishing such  
a service, an extensive and exhaustive study be made  
of the following:
- (a) The American Hospital Pharmacy

- (b) The method of selection for  
a hospital formulary, and
- (c) Other appropriate services, systems  
or methods available and acceptable  
(iii) That a Federal grant, in the

amount of \$1,000 be established to enable this project  
the members of the Canadian Society  
of Hospital Pharmacists believe that hospital pharmacists  
and hospital administrators and hospital committees are  
in a better position of the need for the expansion of  
the facilities of the pharmacy department when the



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capacity of the hospital is expanded and of the progress which has been made in the development and the expansion of pharmaceutical service in all hospitals during the last ten years. The Society, therefore recommends:

(i) that the standards in Appendix C be considered "minimum standards" for the setting up of pharmaceutical service in hospitals;

(ii) that an experienced hospital pharmacist, to provide for the proper interpretation and implementation of these standards as they pertain to pharmaceutical service in new and expanded hospitals, be employed by all federal and provincial government agencies which approve hospital plans for construction;

(iii) that plans for the pharmacy departments in new and expanded hospitals, which do not meet the standards in Appendix C, not be approved for construction by federal and provincial government agencies; and

(iv) that payment of federal and provincial grants for hospital construction be contingent upon compliance with standards in Appendix C when new and expanded facilities for the pharmacy department are included in these grants.



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departments in new and expanded hospitals, which do not meet the standards in Appendix C, not be approved for construction by federal and provincial government

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(iv) that payment of federal and

provincial grants for hospital construction be contingent upon compliance with standards in Appendix C when new and expanded facilities for the pharmacy department are included in these plans.





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4 9. To provide the best possible health  
5 care for all Canadians, the members of the Canadian  
6 Society of Hospital Pharmacists believe that every  
7 Canadian is entitled to pharmaceutical service provided  
8 by a pharmacist properly qualified both as to academic  
9 qualification and legal professional registration.

10 Why should this protection be withdrawn when a person  
11 is admitted to a hospital? The Provincial Pharmacy Acts  
12 provide for the handling and the sale of drugs and  
13 medicinal preparations only by authorized persons. The  
14 Society recommends that all Provincial Pharmacy Acts,  
15 in the best interests of hospital patients and public  
16 safety, encompass the practice of pharmacy in hospitals  
17 and hospital pharmacists in such a manner so as not to  
18 permit drugs and medicinal preparations in hospitals  
19 to be compounded and dispensed by unqualified and  
20 unlicensed personnel.

21 10. As of June 30, 1961, there were 392  
22 pharmacists engaged in the practice of hospital pharmacy  
23 in Canada. In the same year, there were 100,747 hospital  
24 beds, or 49% of the total hospital beds in Canada,  
25 without supervised pharmaceutical service performed  
26 by a pharmacist. An additional 2,008 pharmacists would  
27 be required to staff these hospitals adequately, and  
28 approximately 20% of these would be employed on a part-  
29 time basis. By 1980, a total of some 2,600 hospital  
30 pharmacists would be required.

11. To assume the responsibilities outlined  
in Appendix C, section 11, hospital pharmacists should  
be recruited from among students of higher than average





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result in the practice of pharmacy in hospitals  
to be recognized and regulated by unqualified and  
unlicensed personnel.  
As of June 30, 1961, there were 302  
pharmacists engaged in the practice of hospital pharmacy  
in Canada. In the same year, there were 100,707 hospital  
beds, or 44% of the total hospital beds in Canada,  
without supervised pharmaceutical service performed  
by a pharmacist. An additional 2,608 pharmacists would  
be required to staff these hospitals adequately, and  
approximately 40% of these would be employed on a part-  
time basis. By 1980, a total of some 2,610 hospital  
pharmacists would be required.  
To ensure the responsibilities outlined  
in Section 11, hospital pharmacists should  
be recruited from an environment of higher than average



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4 academic achievement. There is no lack of interest in  
5 hospital pharmacy at the present time. The problem is  
6 one of straight competition for pharmacy graduates, due  
7 to the present shortage of pharmacists in all branches  
8 of the profession. Low salary scales deprive the hospital  
9 field of many well trained pharmacists. The Canadian  
10 Society of Hospital Pharmacists recommends that  
11 experienced hospital pharmacists be appointed to pro-  
12 vincial government agencies responsible for hospital  
13 care programmes to assist in the development of  
14 hospital pharmacy in Canada. It is recommended further  
15 that the basic principles outlined in Appendix H be  
16 brought to the attention of the appropriate administra-  
17 tive authorities in the provincial and federal health  
18 services.

17 12. An active research programme in  
18 hospital pharmacy is essential to improve pharmaceutical  
19 service in hospitals. This programme should include  
20 the development of improved hospital pharmacy techniques  
21 and operational research to bring the administration of  
22 the pharmacy department in line with other services in  
23 the hospital. This research is contingent upon the  
24 availability of hospital pharmacists with the required  
25 academic qualifications, ability and experience. The  
26 Canadian Society of Hospital Pharmacists recommends that  
27 sufficient emphasis be placed upon the role of the  
28 hospital pharmacist in research so that alert, capable  
29 and experienced research hospital pharmacists are  
30 available to accept the challenge of work in this  
area when the opportunity is presented to them.







13. The Society believes that high standards of hospital care are necessary to ensure the best possible health care for all Canadians and that measures to improve or upgrade present standards or correct deficiencies in hospital care should receive high priority in any health care programme. The Canadian Society of Hospital Pharmacists therefore recommends that the introduction of other health services should not be provided at the expense of high standards of hospital care.

14. In respect to the provision of pharmaceutical service in Canada's hospitals, the Society recommends the following priorities:

(i) The employment of competent, adequately trained, licensed pharmacists to provide pharmaceutical services in hospitals. As a point of departure, it is suggested that the distribution of licensed pharmacists in Canada is such that few hospitals, if any, could not obtain the services of a pharmacist, at least on a part-time basis.

(ii) The provision of adequate training for hospital pharmacists.

(iii) The provision of adequate physical facilities for the pharmacy departments in hospitals.

15. A continuing programme of education is essential for the practice of pharmacy in hospitals. Academic degrees in pharmacy must be supplemented by properly organized and adequately supervised internship programmes, served in teaching hospitals, and by further







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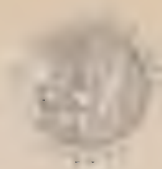
continuing postgraduate education, acquired through specialized courses, institutes, seminars and professional meetings at the national, provincial and local level. Progress in the medical sciences and new developments in the fields of hospital care and hospital administration make this imperative. The Canadian Society of Hospital Pharmacists recommends that grants be provided to the Faculties of Pharmacy providing postgraduate training in hospital pharmacy on the basis of \$5,000.00 annually and to the affiliated hospitals on the basis of \$2,000.00 annually for each student enrolled in the programme. These funds should be provided through federal-provincial health grants on the basis of 2/3 federal and 1/3 provincial.

16. Factors which influence the cost of drugs to individual hospital include:

- (i) supervision by a pharmacist,
- (ii) the size of the hospital,
- (iii) the type of hospital, and
- (iv) the co-operative efforts of administration, medical staff, and the purchaser of drugs.

A survey has shown the lack of inventory control in hospitals which do not employ a pharmacist.

17. The Canadian Society of Hospital Pharmacists, recognizes that most of the provincial hospital plans, include in their benefits to in-patients, all drugs and medicinal preparations, required in the treatment of patients, and recommends that these benefits



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4 be provided to all hospital in-patients in Canada. The  
5 Society further recommends that the payment of federal  
6 grants for hospital operating costs be contingent upon  
7 the provision of full drug benefits.

8 18. The Executive and the members of the  
9 Canadian Society of Hospital Pharmacists wish to express  
10 their appreciation to the members of the Commission for  
11 this opportunity of presenting some views and recommenda-  
12 tions on selected areas of hospital pharmacy in Canada.  
13 If requested by the Commission, the Society will  
14 endeavour to provide any further assistance required.

15 THE CHAIRMAN: Thank you very much  
16 Mr. Stewart. Basically you start with the proposition  
17 there should be a pharmacist in every hospital of 75  
18 beds or more. How do you suggest the 24 hour basis is  
19 taken care of?

20 MR. STEWART: Most hospitals sir where  
21 there is a pharmacist employed they are on call on a  
22 24-hour basis, if necessary, after hours.

23 Usually in a larger centre it is on  
24 an alternating basis, each pharmacist taking his turn  
25 but most of our hospital the pharmacist is on call at any  
26 time day or night.

27 THE CHAIRMAN: The pharmacy operates  
28 only on a day-time basis?

29 MR. STEWART: It operates only on a  
30 day-time basis with the understanding that if there is  
an emergency that a pharmacist is available for  
emergencies.

THE CHAIRMAN: I was noticing in your





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Stewart

as provided to all hospital in-patients in Canada. The Society further recommends that the payment of federal grants for hospital operating costs be contingent upon the provision of full drug benefits.

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It is requested by the Commission, the Society will endeavour to provide any further assistance required.

Mr. Stewart. Basically you start with the proposition there should be a pharmacist in every hospital of 75 beds or more. How do you suggest the 24 hour basis is maintained?

MR. STEWART: Most hospitals are where there is a pharmacist employed they are on call on a 24-hour basis, if necessary, after hours.

Usually in a larger centre it is on an alternating basis, each pharmacist taking his turn but most of our hospital the pharmacist is on call at all times day or night.

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Stewart

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4 Appendix C that you make provision for the nurses having  
5 access to the drug cabinet.

6 MR. STEWART: This is done on the  
7 basis that several items which are known to be frequently  
8 called for in emergency would be pre-dispensed or made  
9 available should they be needed, but still with the  
10 understanding if the pharmacist requires a compound or  
11 to make some special preparation, he or she would come  
12 back to the institution. A matter of making it easy.

13 THE CHAIRMAN: As a practical matter  
14 you say there should be additional licensed pharmacists  
15 for each additional 100 beds or major portion thereof.  
16 Do you seriously suggest that in the Vancouver General  
17 Hospital there should 17 or 18 fully registered licensed  
18 pharmacists?

19 MR. STEWART: Yes sir, I believe that  
20 each 100 beds, active beds providing they are not chronic  
21 beds or beds which require little medication, if it is  
22 an active type hospital it keeps the pharmacist busy.

23 THE CHAIRMAN: You really mean it? You  
24 are putting that forward?

25 MR. STEWART: Yes sir.

26 THE CHAIRMAN: The Vancouver General  
27 Hospital has 1,750, 1,800 beds?

28 MR. STEWART: I am not sure of their  
29 figures but it may be in that area.

30 THE CHAIRMAN: Somewhere in that area?

MR. STEWART: Yes.

COMMISSIONER McCUTCHEON: What about  
your own hospital?



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THE CHAIRMAN: You really need it? You

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MR. STEWART: Yes sir.

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THE CHAIRMAN: Somewhere in that area?

MR. STEWART: Yes.

COMMISSIONER OF HEALTH: What about

your own hospital?





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4 MR. STEWART: We have 13 pharmacists  
5 and we have approximately 1,200 beds. We are a teaching  
6 hospital and we have a great deal of responsibility  
7 besides.

8 We have out-patient work as well as  
9 in-patient work. This is also quite usual in the  
10 bigger teaching hospitals.

11 COMMISSIONER McCUTCHEON: Leaving out  
12 the teaching hospitals, how many general hospitals of  
13 300 beds or more come up to your suggested standard?

14 MR. STEWART: I believe Mrs. Stauffer  
15 worked on a survey and perhaps she can give that  
16 information on the 300 beds.

17 PROF. STAUFFER: Well the surveys  
18 which we did, as you know, were done in 1955 and 1957.  
19 I don't know that we could say a figure but we would  
20 say that not too many do.

21 COMMISSIONER McCUTCHEON: Not too  
22 many?

23 PROF. STAUFFER: No.

24 COMMISSIONER GIRARD: Would you use the  
25 same ratio regarding the number of pharmacists in  
26 hospitals where the central sterilization supply is  
27 also under the pharmacy department or would that change  
28 the ratio?

29 MR. STEWART: There are not too many  
30 institutions where this is true. Usually most of the  
work in the central sterile supply is done by lay help  
supervised by nursing staff, rather than by pharmacists  
other than, say, making a sterile solution which usually







Stewart

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requires pharmaceutical supervision.

COMMISSIONER GIRARD: What is your philosophy regarding this, because I think this is being now discussed very thoroughly in a lot of hospitals that are being built, whether this should or should not be under the pharmacy. This is why I asked the question.

MR. McNAB: If I may speak to that Mr. Chairman. It probably will depend, in great measure, on economy.

COMMISSIONER GIRARD: But if it is under the Pharmacy Department would your ratio still hold?

MR. McNAB: I should imagine you would add one as supervisor for that central supply.

COMMISSIONER GIRARD: One for 24 hours? It is open 24 hours?

MR. McNAB: Yes.

COMMISSIONER GIRARD: Thank you.

THE CHAIRMAN: What do you mean at the end of page 3 that:

"Canadian hospital formulary service,  
"on a subscription basis, be established  
"by pharmacists in Canada."?

MR. STEWART: Maybe I can ask Mrs. Stauffer to answer that because she is familiar with this American Formulary Service which is now in operation.



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It is over in houses?

MR. McNEIL: Yes.

COMMISSIONER GIBBS: Thank you.

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MR. McNEIL: Maybe I can ask that.

Struggles to answer that because she is familiar with

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PROF. STAUFFER: It is operated as a subscription just as any other periodical or journal subscription. The original book which is this copy we have here is purchased for \$15 and then the \$5 a year subscription keeps it up to date.

THE CHAIRMAN: And I suppose the idea is you operate a formulary or resort to a formulary in the hospital?

PROF. STAUFFER: The Pharmacy and Therapeutics Committee in the hospital selects those batches covering those monographs which they wish to have in their formulary.

THE CHAIRMAN: The idea is a formulary in a hospital is so you can fill a prescription through a generic drug?

MR. McNAB: Not necessarily.

THE CHAIRMAN: Apart from looking up definition, but is that not the purpose of it?

MR. McNAB: No, it is intended primarily to provide the best care in respect of drugs with a minimum variety of drugs. As you are probably aware ---

THE CHAIRMAN: Substitution of a prescribed drug by something of equal quality?

MR. McNAB: Not necessarily.

THE CHAIRMAN: Well, drop the "not necessarily" and tell us what it is.

MR. McNAB: It provides the best medical care with a minimum variety of drugs in each therapeutic classification according to the medical







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staff in the hospital.

THE CHAIRMAN: Now, will you relate that to something practical by way of example?

MR. McNAB: For instance, there are seven different brands of tetracycline; if the Medical Advisory Council or governing medical body in a hospital elects or selects brand X for the formulary, that is the brand which is bought.

THE CHAIRMAN: And no matter what the doctor prescribes that is what the patient gets?

MR. McNAB: Under the system, yes.

THE CHAIRMAN: And does that work satisfactorily?

MR. McNAB: In our hospital it does.

COMMISSIONER GIRARD: Would you say this is in order to keep a smaller inventory in the pharmacy; this will help to keep a smaller inventory?

MR. McNAB: It is a possible reduction in inventory but by reducing your purchase from 7 to 1 it also means you can increase your purchase of the individual product. However, based on the total consumption which you need, your hospital pharmacist with conviction, from experience and records, then you may, at a given time, purchase 5,000, 10,000 or 15,000 in which case the inventory is a secondary issue to unit cost which is reduced.

THE CHAIRMAN: Page 8:

"The Society further recommends payment of federal grants to be contingent upon the provision of full drug





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benefits."

What limitation, if any, is there on the providing of drugs now in hospital?

MR. STEWART: We have a feeling that full drug benefits are not present particularly if the patient is not safeguarded by the fact that there are adequately trained staff handling the drugs. To begin with, that they are properly purchased and stored properly and distributed, labelled correctly and checked. This, we feel, is something a patient can expect to have in the hospital.

THE CHAIRMAN: That is what you mean by this paragraph?

COMMISSIONER McCUTCHEON: I do not think so, not if you read it.

THE CHAIRMAN: Not the way I read it.

PROF. STAUFFER: I think there are some provinces in which there are charges made to some categories of drugs and I think this was brought out in the Saskatchewan brief by the Saskatchewan branch of the Canadian Society of Hospital Pharmacists. In Ontario, I believe there are expenses and other provinces where this does not obtain.

THE CHAIRMAN: It makes more sense.

MR. STEWART: Yes, that is true.

THE CHAIRMAN: We did hear representations in Saskatchewan of certain very expensive drugs being withdrawn but I would not go so far as to say it applied to in-hospital services.

COMMISSIONER BALTZAN: Just one point.



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McNab

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I have asked this question previously as to what special preparation of training does the pharmacist have in order to become a hospital pharmacist. I see you have an explanation on page 7, paragraph 15. In this way a man becomes a kind of pharmacist that you would recommend in a post in a hospital. By the same token, just in reverse order, could I ask you this: with your present curriculum of training, is the graduate pharmacist fully prepared to take over a hospital pharmacy?

MR. McNAB: Do you want my personal opinion?

COMMISSIONER BALTZAN: Yours or your confreres.

MR. McNAB: May I answer this?

PROF. STAUFFER: We believe that the basic undergraduate course or the undergraduate course of basic sciences and professional subjects is the basic qualification for any pharmacist and it does apply to hospital pharmacy as well. However, we have felt the need for 10 years in some universities to add electives in hospital pharmacy administration to that basic training and with these electives we do think that this individual is able to take a staff position in a hospital pharmacy and do very well.

However, we feel that the added year's internship in the hospital itself is essential to have a well-qualified hospital pharmacist.

THE CHAIRMAN: In addition to the electives?



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MR. McNEAB: In addition to the





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PROF. STAUFFER: Yes, on the same principle that a medical intern needs a year of experience.

COMMISSIONER BALTZAN: Did you say year or years?

PROF. STAUFFER: A one-year program now.

COMMISSIONER FIRESTONE: Mr. Stewart, I wonder whether we can have one little explanation in this respect: paragraph 7, sub-paragraph (i) of your recommendation on page 3, where you recommend that the Canadian Hospital Formulary Service be established by pharmacists in Canada. Would your group be also prepared to support a Canadian Formulary Service established by pharmacists that would cover both the hospitals as well as other groups? I am thinking of groups of doctors practising in the form of a clinic, group practice, etc., or individual doctors?

MR. STEWART: I believe if the Hospital Formulary Service was begun and available in all hospitals that physicians would be at liberty to obtain such for their office use or for clinic use. This would be purely selfish if it was not available to all people professionally competent to use it.

COMMISSIONER FIRESTONE: So one could take that as meaning a service for people of the medical professions and hospitals as well?

MR. STEWART: Yes, although we do not wish to speak for the other parts of pharmacy but this, no doubt, would pertain to a large degree - doctors





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STANLEY

PROF. T. J. L. ... Yes, on the same

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I wonder whether we can have one little expansion in

this part: paragraph (1) of your

recommendation on page 2, where you recommend that

the Canadian Hospital Fellowship Service be established

in hospitals in Canada. Would your group be also

prepared to support a Canadian Fellowship Service

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profession and hospitals as well.

MR. STANLEY: Yes, although we do not

wish to speak for the other parts of the profession but this,

no doubt, would result in a large degree - doctors



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would be used to these formularies in the hospital and would now wish to use them in their clinics.

MR. McNAB: As a matter of fact, that has been our experience; we have had several doctors request copies of this publication.

COMMISSIONER BALTZAN: It is true it is not entirely a new idea, it is only an advancement of the things that have gone on in hospitals in this country for many years?

MR. STEWART: Many hospitals have had their own formularies going back even 20 or 30 years.

COMMISSIONER GIRARD: You see any reason why a small hospital that has not developed its own formulary cannot adopt a formulary of another hospital?

MR. STEWART: I do not see any reason at all and if this service was available and they wanted to limit it they could choose only the monographs that they wish to use; they would not have to include in their formulary all the specialized preparations available.

COMMISSIONER STRACHAN: When you speak of a pharmacist for every 100 beds, how does this compare to the requirement of the Canadian Council on Hospital Accreditation? What are their standards of requirement?

PROF. STAUFFER: I think in Appendix D we have their standards which you can see. It does not indicate anything about the number of pharmacists in relationship to bed capacity. It says:





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"There shall be a pharmacy directed  
by a registered pharmacist or a  
drug room under competent supervision."

COMMISSIONER STRACHAN: One other  
thing; as I understand it, in some provinces of Canada  
it is necessary that a pharmacist be in attendance  
while a retail pharmacy is open. How does this affect  
the suggestion of the service of a retail pharmacist  
on a part-time basis in hospital? Is it very practical?

PROF. STAUFFER: According to our  
minimum standards and our definition of a pharmacist  
and a pharmacy, we believe the pharmacist should be  
in attendance when the pharmacy is open. If we have  
a retail pharmacist in the hospital on a part-time  
basis then he would be in attendance in the hospital  
when the pharmacy was open.

COMMISSIONER McCUTCHEON: He would not  
be in attendance at his own pharmacy, that is what he  
means. Does he close the store?

THE CHAIRMAN: He just has to close  
the pharmacy, just pull down the shutter.

COMMISSIONER STRACHAN: I thought  
that section had to open, in some provinces, as long  
as the store is open.

PROF. STAUFFER: I think we, as a  
Canadian Society of Hospital Pharmacists, representing  
a national group, would not enter into any discussion  
with regard to provincial Pharmacy Acts other than  
we feel they should encompass pharmacists and pharmacies  
in hospitals as well as all other pharmacists.







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TORONTO, ONTARIO

Stauffer

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THE CHAIRMAN: A very sensible answer.

COMMISSIONER STRACHAN: I was wondering how it worked out on a practical basis. How many part-time pharmacists are employed?

PROF. STAUFFER: Very few.

MR. McNAB: It is only practical on the basis of having at least two men.

THE CHAIRMAN: You have a small town in which there is a small hospital; you have to work out a live-and-let-live process. It is a matter of common sense.

MR. STEWART: It is being done.

THE CHAIRMAN: Thank you very much.



THE WATKINS: A very serious answer.

MR. STRONG: I was

wondering how it would be on a practical basis.

Now many practical objections are involved.

MR. MOORE: It is only practical

on the basis of having at least two men.

MR. CHAIRMAN: You have a small town

in which there is a small hospital; you have to work

out a five-and-ten-five process. It is a matter of

common sense.

MR. CHAIRMAN: Thank you very much.

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4 THE SECRETARY: The next submission  
5 is that of the Canadian Society of Hospital Pharmacists,  
6 Ontario Branch which will be known as exhibit 296.

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8 SUBMISSION OF  
9 CANADIAN SOCIETY OF HOSPITAL PHARMACISTS,  
10 ONTARIO BRANCH

11 ---EXHIBIT NO. 296: Submission of the Canadian  
12 Society of Hospital  
13 Pharmacists, Ontario  
14 Division.

15  
16 APPEARANCES: Mr. Richard Tompson  
17 Miss Carolyn Crawforth  
18 Mr. Charles Burnie.

19 MR. TOMPSON: Mr. Chairman and members  
20 of the Commission I am R. Tompson, Richard Tompson,  
21 president of the Ontario branch of the Canadian Society  
22 of Hospital Pharmacists and chief pharmacist at the  
23 Sunnybrook Hospital in Toronto. On my right is Miss  
24 Carolyn Crawforth, secretary of the Ontario Branch,  
25 Canadian Society of Hospital Pharmacists and assistant  
26 chief pharmacist at Women's College Hospital, Toronto,  
27 Ontario. On my left is Mr. Charles Burnie who is a  
28 member of the committee which prepared our submission  
29 and is president of the Western Chapter of this Ontario  
30 branch.

1. This submission is respectfully  
presented by the Ontario Branch of the Canadian Society  
of Hospital Pharmacists; a voluntary organization of







Tompson

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4 pharmacists who practise in Ontario hospitals. Hospital  
5 Pharmacists are associated with two health services -  
6 pharmacy and hospitals. Therefore the Ontario Branch  
7 has asked your permission to present such information,  
8 opinions and recommendations as vitally concerns the  
9 practice of pharmacy in Ontario Hospitals.

10 2. The hospital pharmacist is responsible  
11 for the procurement, storage and distribution of all  
12 drugs and diagnostic agents used in the hospital. The  
13 functions of the department vary depending on the type  
14 of hospital, location and bed capacity. The various  
15 procedures are listed in paragraph 9 and Appendix C.

16 3. In many Ontario hospitals the pharmacy  
17 department is not in charge of a legally qualified  
18 pharmacist. The Canadian Society of Hospital Pharmacists  
19 recommends that a hospital of 75 beds or more employ  
20 a graduate pharmacist full-time and an additional  
21 pharmacist for each 100 beds or major portion thereof.  
22 From a review of information contained in the Canadian  
23 Hospital Directory (page 8) it is shown that 47.8% of  
24 hospital beds in Ontario are not covered by professional  
25 pharmaceutical service - 34,841 -- I must include in  
26 here another figure, 30,162 should be added after that  
27 figure so it will read 30,162 of these beds contained  
28 in hospitals of 75 or more beds -- It is felt that  
29 this is not consistent with the highest standards of  
30 patient care.

31 4. The Ontario Branch notes with concern  
32 the fact only 2 of Ontario's Mental Hospitals employ a  
33 Pharmacist. Today pharmaceuticals are being used



pharmacists who practice in Ontario hospitals. Hospital  
 pharmacists are associated with two health services -  
 pharmacy and hospitals. Therefore the Ontario branch  
 has asked your assistance to present such information,  
 opinions and recommendations as vitally concern the  
 practice of pharmacy in Ontario hospitals.

The hospital pharmacist is responsible  
 for the procurement, storage and distribution of all  
 drugs and diagnostic agents used in the hospital. The  
 functions of the department vary depending on the type  
 of hospital, location and bed capacity. The various  
 procedures are listed in paragraph 9 and Appendix C.

In many Ontario hospitals the pharmacy  
 department is not in charge of a legally qualified  
 pharmacist. The Canadian Society of Hospital Pharmacists  
 recommends that a hospital of 75 beds or more employ  
 a graduate pharmacist full-time and an additional  
 pharmacist for each 100 beds or major portion thereof.  
 From a review of information contained in the Canadian  
 Hospital Directory (page 8) it is shown that 47.8% of  
 hospital beds in Ontario are not covered by professional  
 pharmaceutical service - 30,541 -- a most inadequate  
 service. Another 11,000, 30,162 should be added after that  
 figure so it will read 30,162 of these beds contained  
 in hospitals of 75 or more beds -- It is felt that  
 this is not consistent with the highest standards of  
 patient care.

The Ontario Branch notes with concern  
 the fact that only 2 of Ontario's medical schools employ a  
 pharmacist. Today pharmacists are being used





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3 extensively in the treatment of the mentally ill.

4 5. The Ontario Branch deplores the fact  
5 that the Ontario Pharmacy Act does not cover hospital  
6 pharmacies in its jurisdiction. While it is recognized  
7 that small hospitals (74 beds or under) would find it  
8 impossible to employ a pharmacist full-time it is  
9 respectfully recommended that the Ontario Law should be  
10 revised to include hospital pharmacies. The Canadian  
11 Council on Hospital Accreditation names pharmacy as one  
12 of the essential services in a hospital (Appendix D)  
13 and states that there shall be a graduate pharmacist  
14 in charge. The minimum standards for the practice  
15 of pharmacy in Canadian hospitals (Appendix C -1-1) also  
16 specifies that a graduate be in charge of the department.  
17 In the Province of Ontario there is no law to provide  
18 such protection for the hospital patient.

19 6. The Ontario Branch recommends the  
20 establishment of a formulary service for the use of  
21 Ontario hospitals. It is believed that the formulary  
22 system provides valuable assistance in dispensing  
23 pharmaceuticals in a hospital.

24 7. It is respectfully submitted that there  
25 is a serious shortage of pharmacists employed in Ontario  
26 hospitals (reference paragraph 27 - 32) and that this  
27 situation is detrimental to health services provided in  
28 the province. The most obvious contributing factor  
29 to this present man power status is the low salary  
30 scale paid to hospital pharmacists. Hospital pharmacy  
must compete with the retail, industrial and academic  
branches of pharmacy for its personnel. It is recommended





extensively in the treatment of the mentally ill,  
The Ontario Branch reported the fact  
that the Ontario Branch has not been hospital  
pharmacies in its jurisdiction. While it is recognized  
that all hospitals (public or private) would find it  
difficult to employ a pharmacist full-time it is  
recommended that the Ontario law should be  
revised to include hospital pharmacies. The Ontario  
Council on Hospital Administration has pharmacy as one  
of the essential services in a hospital (Appendix "C")  
and states that there shall be a graduate pharmacist  
in charge. The minimum standards for the practice  
of pharmacy in Canadian hospitals (Appendix "C-1") also  
specify that a graduate be in charge of the department.  
In the Province of Ontario there is no law to provide  
such recognition for the hospital pharmacist.  
The Ontario Branch recommends the  
establishment of a pharmacy service for the use of  
Ontario hospitals. It is believed that the pharmacy  
service would be valuable assistance in hospital  
pharmacy service in a hospital.  
It is respectfully submitted that there  
is a serious shortage of pharmacists employed in Ontario  
hospitals (reference paragraph 2 - 3) and that this  
situation is detrimental to public service and in  
the province. The most obvious contributing factor  
to this is the low status and low salary  
paid to hospital pharmacists. Hospital pharmacy  
must compete with the retail, industrial and academic  
branches of pharmacy for its personnel. It is recommended



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3 that principles contained in Appendix C and information  
4 contained in Appendix E be brought to the attention of  
5 the authorities governing hospitals in Ontario.

6 8. It is a matter of concern that a  
7 greater percentage of students at the Faculty of  
8 Pharmacy, University of Toronto, do not enter the  
9 hospital pharmacy specialty (Paragraph 33-36). It is  
10 further recommended that opportunities for post-graduate  
11 study to prepare candidates for administrative positions  
12 should be expanded (paragraph 37).

13 To date only one hospital in Ontario  
14 is offering a post-graduate internship in hospital  
15 pharmacy.

16 9. According to figures available it is  
17 apparent that the cost of drugs used in hospitals has  
18 not increased unduly over the past few years. In the  
19 Province of Ontario the insurance plan operated by the  
20 Ontario Hospital Services Commission covers "all drugs,  
21 biologicals and related preparations required by the  
22 patient in accordance with accepted medical practice",  
23 except proprietary or patent medicines. It is  
24 commendable that every patient receives whatever medica-  
25 tions necessary for treatment regardless of type or cost  
26 of the same. (Paragraph 45).

27 10. Different types of research may be  
28 carried on in hospital pharmacies. This will vary  
29 considerably depending on the size of the hospital and  
30 the operations which are carried on by the pharmacy  
department (paragraph 49).

11. The Ontario Branch of the Canadian







Tompson

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4 Society of Hospitals. Pharmacists consider that the  
5 maintenance of high standards of patient care in  
6 hospitals are essential in the operation of this health  
7 service. Any extension of government sponsored health  
8 services should not be at the expense of hospital care.  
9 12. The executive and members of the  
10 Ontario Branch of the Canadian Society of Hospital  
11 Pharmacists wish to express their appreciation to the  
12 members of the Health Services Commission for this  
13 opportunity to express the above opinions and recommenda-  
14 tions regarding the practice of pharmacy in Ontario  
15 Hospitals. May we assure you of our continued interest  
16 in the work of the Commission and our desire to assist  
17 in any way possible.

18 THE CHAIRMAN: Thank you, Mr. Tompson.  
19 As you will appreciate your submission parallels very  
20 closely that of the Canadian Society of Hospital  
21 Pharmacists, and the only element of difference might  
22 be insofar as Ontario is concerned.

23 MR. TOMPSON: That is right, sir.

24 THE CHAIRMAN: One point, you  
25 enunciated you have no complaints about any drugs being  
26 kept from the patients in Ontario hospitals?

27 MR. TOMPSON: I am sorry, sir, I  
28 didn't catch what you just said.

29 THE CHAIRMAN: You don't complain about  
30 patients in the Ontario hospitals being deprived of any  
drugs?

MR. TOMPSON: No, they get them.

THE CHAIRMAN: You refer to the





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4 Hospital Accreditation program in exhibit D and you said  
5 that it contained a provision that there shall be a  
6 pharmacy directed by a registered pharmacist, and  
7 the clause, of course, continues or a drug room under  
8 competent supervision. What is the difference between  
9 a pharmacy or a drug room? Is it, and I am perhaps  
10 answering the question myself, is a drug room simply  
11 a place where there are certain prepared and labelled  
12 drugs which somebody may pick up off the shelf as  
13 distinct from a pharmacy where judgment is exercised  
14 in the compounding or selection of the drug?

15 MR. TOMPSON: I am afraid that the  
16 words "drug room" is a phrase used that is probably now  
17 archaic. Unfortunately the word "hospital pharmacy"  
18 has sometimes now been given the name hospital pharmacy  
19 when probably it is still a drug room. We understand  
20 the hospital pharmacy is one which has a hospital  
21 pharmacist in charge.

22 THE CHAIRMAN: When you get into a  
23 discussion and say that legislation in Ontario is  
24 deficient in those cases where there are drugs stored  
25 and handled with no pharmacist present it may be this  
26 is the very thing of a drug room.

27 MR. TOMPSON: Our idea is that there  
28 shall not be such a thing as a drug room. The drug  
29 room, to our idea, allows it to be handled by some person  
30 other than a hospital pharmacist or legal qualified  
pharmacist. I could almost say we hardly recognize the  
phrase as being -- should not be.

THE CHAIRMAN: You say we want the





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standards that are set down by the Hospital Accreditation people, and these are the very people you make the judge of the standards and they use the expression.

MR. TOMPSON: We should have included a drug room under competent supervision, in the phrase, to make it legal.

THE CHAIRMAN: I am not suggesting there is anything wrong in the way you put it. It is maybe the answer to your Ontario legislation. You recommend the establishment of formulary services for the use of Ontario hospitals. You were present when the discussion took earlier?

MR. TOMPSON: We go right along with that. If it cannot be done in Ontario by Ontario pharmacists we would like to see it done by some person. If it is done on a Dominion scale I would say the Ontario pharmacists would benefit by that and go along with it. We think it is a necessary thing.

THE CHAIRMAN: You think it is a workable thing?

MR. TOMPSON: We think it is a workable thing. We think it would be a wonderful guide, not only to the large hospital, but also to the smaller hospitals in Ontario.

THE CHAIRMAN: Do you think it also might have the effect of lowering the cost of drugs to patients?

MR. TOMPSON: We think there has been no doubt that will not -- it is bound to affect the proper control of inventories, proper control of the pharmacy, so that by doing this it will affect to a great







Tompson

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extent the cost, the actual drug costs in the hospital,  
yes.

THE CHAIRMAN: Affect downward?

MR. TOMPSON: Yes, definitely downward.  
Maybe not necessarily. I think it is a good possibility  
it will bring to the attention of the doctors that there  
may be better pharmaceuticals that they might use and  
which are more expensive, but we presume that it will  
probably cause better use of drugs and therefore it  
would have better patient care, not necessarily entirely  
economical.

MR. BURNIE: I would like to bring  
one point missed in that discussion. Mr. McNab pointed  
out there are seven brands of Tetracycline, it is possible  
a pharmacy may only carry four and if a doctor insists  
on the seventh brand it is pretty difficult to obtain,  
and maybe has to be obtained from out of town. There  
is a delay in getting the drug for the patient. That  
is what cuts down on the efficiency of getting the drug  
to the patient.

THE CHAIRMAN: The detailman has got  
to the doctor before he got to the druggist. He has  
been sold on the idea of using the new drug?

MR. BURNIE: Just a different brand.

THE CHAIRMAN: This new brand before  
the druggist has stopped him.

MR. BURNIE: Yes. No matter how  
many brands there are on the market it is very seldom  
a pharmacist carries all of the brands because some are



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extent of the case, the patient may be in the hospital.

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Now, not necessarily. I think it is a good possibility  
it will come to the attention of the doctors that there  
may be better cases than the first that was seen and  
which was not answered, but a response that it will  
probably come better as a thing and that it is  
not a case of the same kind, but necessarily entirely

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one point about it that is discussed. It is an old case  
out of the old case of the hospital. It is possible  
a patient may only come from and a doctor may  
in the hospital and it is possible that it is not  
the same as to be out of the hospital. There  
is a delay in getting the data for the patient. That  
is what is the main point of getting the data  
to the hospital.

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of the doctor's data for the hospital. It is  
not a case of the same kind of being the new case.

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the case is not stopped.

any case that is in the hospital is a case of the  
a patient may be in the hospital and it is possible



Tompson

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4 peculiar in certain areas, where the pharmaceutical  
5 manufacturing firm is, perhaps, and sometimes the  
6 doctor goes to a convention and the next day comes back  
7 and orders this particular new brand. Naturally the  
8 pharmacist hasn't got it. There is a delay in providing  
9 this drug to the patient.

10 THE CHAIRMAN: And the patient does  
11 without it in the meantime.

12 MR. BURNIE: If the doctor insists.  
13 Usually doctors are reasonable, but there are times when  
14 the doctor will insist this particular brand be used.

15 THE CHAIRMAN: How is the substitution  
16 made?

17 MR. BURNIE: No substitution is made.

18 THE CHAIRMAN: Change made -- you say  
19 the doctor is reasonable, is it the pharmacist that  
20 phones the doctor and says I don't have Brand A, but  
21 I have got Brand B?

22 MR. BURNIE: That is right.

23 THE CHAIRMAN: He says, fine, you  
24 change it?

25 MR. BURNIE: Still some delay could  
26 occur even after this, if the doctor has since gone  
27 out to play golf.

28 COMMISSIONER McCUTCHEON: They never  
29 play golf.

30 THE CHAIRMAN: They never have a day  
off.





...in certain cases, where the pharmaceutical

...time is, perhaps, and sometimes the

...to a certain point and the next day comes back

...and orders this particular new brand. Naturally the

pharmacist hasn't got it. There is a delay in receiving

the drug to the patient.

...and the patient has

without it, the situation.

...but there are times when

the doctor will insist this particular brand be used.

THE CHAIRMAN: How is the substitution

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THE CHAIRMAN: Change name -- you say

...the doctor is reasonable, is it the pharmacist that

...change the doctor and says I don't have brand A, but

I have got brand B.

MR. JENNIFER: That is right.

THE CHAIRMAN: Is that, then, you

...

...delay would

...to the doctor has since then

out to that point.

play role.

THE CHAIRMAN: When do you have a day

...



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COMMISSIONER FIRESTONE: Mr. Thompson, in Paragraph 45 on Page 19 you say in the last sentence of that paragraph: "Under the Ontario Plan," and I quote: "no provision is made for take-home drugs". Have you any recommendations with respect to take-home drugs?

MR. TOMPSON: We do have --- this can be qualified to some extent. At the present time in most hospitals, in order not to cause a problem to the patient in getting his prescription filled, very often a supply is allowed for the patient to take home sufficient in order that it can last him for the number of doses required, in order that he does not have to interrupt his treatment, especially if it is a fairly important drug that he is taking, but that is the only area where we are allowed to dispense enough of take-home drugs.

This is what you are asking, if you are asking me if I approve of allowing patients to take home larger quantities of drugs dispensed by the hospital, and that the Ontario Hospital Service Commission should pay for these, is that the question?

COMMISSIONER FIRESTONE: Well, you can interpret it that way. I am referring to the statement which you have made, and I am just wondering if, having made the statement, whether you have any thoughts as to whether that coverage should be extended?

MR. TOMPSON: We don't think this is necessary at the hospital level, that the hospitals are then going to compete with their retail partners, and it is not a hospital service to do this. We treat the patient while in hospital or the out-patient clinic, but





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not to enter into competition with the retail pharmacists. If we did that, I am sure that the expensive drugs would start being curtailed by the Ontario Hospital Service Commission. A patient could quite easily come into hospital for one day and go home with the equivalent of 20 or 30 days treatment in drugs alone.

COMMISSIONER FIRESTONE: Could that not be achieved on the basis that the patient be given the drugs to complete his treatment?

MR. TOMPSON: I didn't say to complete his treatment. I said to be sure that his treatment would not be interrupted, until he could get his prescription filled at his drugstore.

COMMISSIONER FIRESTONE: What does that really mean in practice?

MR. TOMPSON: Well, in practice say we discharged a patient from Sunnybrook Hospital who was going to catch a plane at Malton, going back to the place he was brought in from, say Kapuskasing, and it was on a Friday night that he was being discharged. We would give him enough medicine to allow him to not interrupt his treatment until such time as he could have that filled, possibly at some time at noon on Monday. If there was any possibility that the drugstore in Kapuskasing might not have this medicine, then we might even further extend that and allow him probably another week on top of that, to make sure that the drugstore would have it. Otherwise we use a reasonable latitude towards this, but we don't extend this into a complete idea of allowing the patient to go home with a month's or two years' supply







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of the drug if he is going to be on it for an interminable length of time.

COMMISSIONER FIRESTONE: If that patient is an indigent patient, and he says to the head nurse, or the treating doctor, that he cannot afford to buy those drugs when he gets home, what happens then?

MR. TOMPSON: Well, then he is treated by his own municipality. He appeals to them through the welfare services to have the cost of his prescription picked up by the welfare services of his municipality.

COMMISSIONER FIRESTONE: We have been hearing of cases where this is difficult to arrange.

MR. TOMPSON: Well, it is also difficult for the hospital pharmacist to decide whether he is going to look after a patient on this basis. He has no ability to assess the financial ability of this man, his poorness sort of thing.

COMMISSIONER FIRESTONE: I accept it quite readily, sir. I am just wondering what is the practice?

MR. TOMPSON: The practice is that we don't give them take-home drugs. Any extension of this service by the Ontario Hospital Service Commission has not given us the right to do it.

MR. ISBISTER: In answer to a question raised by Mr. Strachan, and that was the feasibility of using part-time pharmacists and reconciling that with the requirements of Provincial Statutes, which apparently require hour by hour and minute by minute supervision, the Provincial Statute, on its face, would appear to require



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of the drug if he is going to be on it for an indefinite  
length of time.

COMMISSIONER: If that

patient is an indigent patient, and he says to the head  
nurse, or the treating doctor, that he cannot afford to  
buy these things when he gets home, what happens then?  
MR. TAPPAN: Well, then he is treated

his own municipality. He applies to them through the  
various agencies to have the cost of his prescription  
paid by the municipality or some of his municipality.  
COMMISSIONER: Well, we have been  
talking of cases where this is difficult to arrange.

MR. TAPPAN: Well, it is also

difficult for the hospital authorities to decide whether  
he is going to look after a patient on this basis. He  
has no ability to assume the financial liability of this  
case, his poorest sort of thing.

COMMISSIONER: Well, I accept it

quite readily, sir. I am just wondering what is the

MR. TAPPAN: The service is that we  
don't give them medicine gratis. Any extension of this  
service by the Ontario Hospital Service Commission has  
not given us the right to do it.

MR. TAPPAN: In answer to a question  
raised by Mr. Stewart, and what was the responsibility of  
the hospital authorities and providing them with the  
regimentation of the various patients, which apparently  
requires from a hour and minute of minute supervision,  
the Province has accepted on its side what appears to be



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that sort of supervision, but the Commission might be interested to know that our Courts have given that Section some elasticity, recognizing the fact that on some occasions a pharmacist must absent himself from his store, and notwithstanding the quite strong language of this Act, it recognizes the proposal that part-time pharmacists be used to staff hospitals, particularly in smaller areas, where the cost of a full-time pharmacist may be prohibitive. This proposal is in my submission, sir, feasible, and within the Ontario Statute.

THE CHAIRMAN: We are grateful to you for that, Mr. Isbister.

That is all, thank you very much, and after today we should know a little more about the drug industry, and drug distribution, and so forth, and we are grateful to you all for the help you have been.

We will rise until 9:30 on Tuesday morning.

---Adjournment.





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that sort of supervision, but the Commission might be  
 interested to know that our Courts have given that section  
 some effectivity, recognizing the fact that on some  
 occasions a pharmacist must absent himself from his store  
 and notwithstanding the above strong language of this  
 Act, it recognizes the proposal that part-time pharmacists  
 be used to staff hospitals, part entirely in smaller  
 areas, where the cost of a full-time pharmacist may be  
 prohibitive. This proposal is in my submission, six,  
 feasible, and within the public interest.

THE CHAIRMAN: We are grateful to you

for that, Mr. Johnston.

That is all, thank you very much.

and after that we should know a little more about the  
 drug industry, and its distribution, and so forth, and  
 we are grateful to you all for the help you have been.  
 We will reconvene until 1:30 on Tuesday.

Meeting.















